Exhibit SS

2-2-2018

Dr. Frankel

Please add to the File Review for:

Joseph Carrillo EID#: 0457172

Diplomate American Board of Neurology
Mario R. Aguilar M.D., P.C.
1240 S. Telshor Blvd, Suite C, Las Cruces, NM 88011-4731
Phone # (575) 522-1212 / Fax # (575) 522-2898

NEUROLOGY FOLLOW-UP

PATIENT: **Joseph Carrillo**
GENDER: **Male**
DOB:
AGE: **31y**

PRIMARY CARE PROVIDER: **Saenz, Mia NP**

DATE OF VISIT: **01/25/2018**

CHIEF COMPLAINT
Episode of unresponsiveness.
Paresthesia in the right arm, torso and right leg.
Headache.

SUBJECTIVE
I reviewed the symptoms outlined on his 08/07/2017 visit.

Patient provided the history:

Episode of unresponsiveness.

Patient stated having experienced an episode of unresponsiveness at the end of June 2017.
He denied previous episodes of unresponsiveness or recurrences.

Description: See H&P.

Headaches.
Headaches have resolved for the most part.

Hypersensitivity:

It has been resolving. The only area, which has been affected is in the back of his thigh.

He denied new neurologic symptoms.

HISTORY OF PRESENT ILLNESS
DATE OF INITIAL CONSULTATION: 08/07/2017

Patient provided the history:

Onset
Patient stated having experienced an episode of unresponsiveness at the end of June 2017.
He denied previous episodes of unresponsiveness or recurrences.

Description
He woke up at 4:45 am and was getting ready to go to work when he experienced the episode of unresponsiveness. There was no warning.
He recalled brushing his teeth next he is in the bathroom on the floor being helped by his girlfriend.

He reported being told the his breathing was slow and was snoring.
His arms were initially shaking.
His body became limp afterwards.
There was no bowel or bladder incontinence.
There was tongue biting across his tongue worse in the right side.

The duration of the episode is unknown. His girlfriend heard him snoring and went to check on him.

He woke up not knowing what had happened.

He recalled experiencing skin hypersensitivity to light touch in the right side of the body and numbness in the back of his right thigh.

He had a headache when he woke up.

He felt nauseated but he did not vomit.

He went to see Dr. Saenz that day and underwent blood tests.

There was no specific treatment.

Currently.
Headaches. He never had similar headaches. The headaches have been constant since the episode of unresponsiveness. The headaches have been located in the frontal region, left temple and eyes. He described the pain as throbbing and at times severe. He has taken ibuprofen, which does not help.

Hypersensitivity: Patient has been experiencing discomfort (hypersensitivity of skin to light touch) in the right arm, right abdomen, chest and leg (right side).

Tiredness. He feels tired in the mornings.

He has had lower back pain: The pain has recurred at times. The pain has been localized to the lower back. It does not radiate to the legs.

He also described morning stiffness.

He reported having had difficulty recalling phone numbers and passwords.

He reported anxiety episodes since the episode.

He had anxiety before.

He did not know if he injured his head at the time of unresponsiveness. There were no head lumps or lacerations.

He reported being a diesel electrician and works on locomotives.
He is not working at this time.

He denied double vision, blindness, speech or swallowing problems.
He denied focal weakness. He denied sphincteric dysfunction.

He has taken Gabapentin for years for paresthesias (numbness and tingling) in his right fingers.

MEDICAL / SURGICAL & HOSPITALIZATION HISTORY

Patient denies any new medical problems from previous visit. Patient denies any new surgeries from previous visit. Patient denies any hospitalizations since previous visit.

REVIEW OF SYSTEMS

Cardiovascular System Reviewed
Patient denies Chest Pain. Patient denies Palpitations. Patient denies Dyspnea on Exertion.

Constitutional System Reviewed
Patient denies Weight loss. Patient denies Fever. Patient denies Chills.

PAST MEDICAL HISTORY

He has had right elbow surgery twice. He reported having had a fatty liver.

PAST SURGICAL HISTORY

He has had right elbow surgery twice.

MEDICATIONS

No changes
Active Medications
• gabapentin 600 mg tablet. Take 2 tablets by mouth at bedtime QHS. Do not substitute.

ALLERGIES

No changes
• No Known Allergies (Mild): Recorded on 08/07/2017. Reactions: None noted.

OBJECTIVE

Vital Signs
Added vitals entry: Measurement date: 2018-01-25 08:41 Weight: 167.0 lbs Height: 5 ft 6.0 in BMI: 27.0
Heart rate: 60 bpm Blood pressure: 120 / 70 mmHg Respiration Rate: 20 breaths per minute

General
The patient is well developed. The patient is well nourished. The patient is in no acute distress. The patient's head shows no recent trauma. There is no proptosis in the right eye. There is no proptosis in the left eye.

The patient's neck is supple without any adenopathies or bruits. The patient's lungs are clear. The patient's heart is regular.

Mental Status
Patient is awake. Patient is alert. Patient is cooperative. Patient is attentive. Patient is appropriate. The patient's speech is unremarkable.

Cranial Nerves
Cranial Nerve II - Optic
The patient's right fields are full. The patient's left fields are full.

Cranial Nerve III - Oculomotor
The patient's right pupil is 2 mm in size. The patient's left pupil is 2 mm in size. The patient's right pupil is reactive to light. The patient's left pupil is reactive to light. There is no ptosis in the right eye. There is no ptosis in the left eye. The patient's right eye shows normal adduction. The patient's left eye shows normal adduction. The patient's right eye shows normal upward movement. The patient's left eye shows normal upward movement. The patient's right eye shows normal downward movement. The patient's left eye shows normal downward movement.

Cranial Nerve IV - Trochlear
The patient's right eye shows normal intorsion. The patient's left eye shows normal intorsion.

Cranial Nerve VI - Abducens
The patient's right eye shows normal abduction. The patient's left eye shows normal abduction.

Cranial Nerve VII - Facial
There is no weakness of the right frontalis. There is no weakness of the left frontalis. There is no weakness of the right orbicularis oculi. There is no weakness of the left orbicularis oculi. There is no weakness of the right orbicularis oris. There is no weakness of the left orbicularis oris.

Cranial Nerve IX - Glossopharyngeal
The patient's palatal motion is normal.

Cranial Nerve XII - Hypoglossal
The patient's tongue movements are normal. The patient's tongue shows no atrophy. The patient's tongue shows no fasciculations.

Motor
There is no Weakness in the Right and Left Thumb, Index Finger, Middle Finger, Ring Finger, or Little Finger. There is no Hand Grip Weakness. There is no Wrist Weakness. There is no Elbow Weakness. There is no Shoulder Weakness. There is no weakness in the Right or Left Toe. There is no weakness in the Right or Left Foot. There is no weakness in the Right or Left Knee. There is no weakness in the Right or Left Hip. There is no cogwheeling rigidity in the patient's Wrists, Arms, or Legs. There is no resting tremor in the patient's Lips or Hands. There is No Postural Tremor in the patient's Hands. There is no Bradykinesia. There are no Dyskinesias of the Head, Arms, Hands, or Legs.

Cerebellar

The patient's right finger-to-nose test is normal. The patient's left finger-to-nose test is normal. The patient's right rapid alternating movements of fingers are normal. The patient's left rapid alternating movements of fingers are normal.

Station & Gait
The patient gets out of a chair and onto the examination table well. The patient is able to perform Romberg's maneuver well.

STUDIES

Blood Tests
07.01.2017-8:18A at Fletcher Flora Lab:
CMP: Glucose 116 H (65-100).
ALT: 138 H (10-40). AST 78 H (9-44).
CBC and TSH: Unremarkable.
Lipid panel: cholesterol 223 H (20-200), triglycerides 208 H (0-150), HDL 33 L (40-60). Ma.

10.24.2017-1231 at MMC:
B12, RPR, ANA, IFE, Anti-Hu antibodies and ESR were unremarkable. Ma.

Neuro Imaging
PATIENT: Joseph Carrillo
DOB: 5/23/1986
MRN: 100000552974
PHYSICIAN: Mario Aguilar, MD
EXAM DATE: 8/16/2017
MRI, Brain c/s Contrast Brain :
HISTORY: Headaches. Weakness. Memory loss.
REFERENCE : None available in PACS.
TECHNIQUE: Multi-planar and multi-sequential MR images of the brain were performed. Without and with IV contrast, Magnevist contrast 15 cc. No contrast reaction reported.
FINDINGS:
BRAIN:
Cerebrum: No intracranial hemorrhage, cerebral edema, diffusion restriction, or mass lesion.
Basal Ganglia: Normal caudate nuclei and lentiform nuclei.
Thalami: Normal.
Cerebellum: No abnormality.
Brain stem: No suspicious lesion.
Ventricles and CSF spaces:
Cortical sulci and basilar cisterns are unremarkable.
Ventricles are normal in size.
Expected flow-voids are patent.
Sella and Pituitary gland: Normal.
Orbits: Normal.
CALVARIUM:
No significant extracranial soft tissue swelling.
SINUSES and MASTOID AIR CELLS and etc.:

Visualized paranasal sinuses are clear.
Mastoid air cells are clear.
Post enhancement:
Images obtained after the contrast injection show no enhancing abnormalities.
IMPRESSION:
1. Normal MRI examination of the brain.
2. No abnormal enhancement.

Dictation site: SVIPAC-TCSV102R

This document has been reviewed and Signed by: Benjamin Wang on 8/16/2017 11:59 AM

10.13.2017 MRI cervical spine without contrast at TIC showed:
IMPRESSION:
No demyelinating lesions or myelomalacia. Mild disc bulge at C5-6 with no canal stenosis, cord compression or nerve root impingement. Ma.

10.13.2017 MRI thoracic spine without contrast at TIC showed:
IMPRESSION:
Unremarkable non-contrast enhanced MRI of the thoracic spine. Ma.

Electrophysiological Studies
08.22.2017 at MMC:
EEG: Normal awake EEG as per Dr. Aguilar. Ma.

CLINICAL IMPRESSION
In essence, this is a 31-year-old male with an episode of unresponsiveness in the latter part of June 2017.

He denied recurrences:
MRI brain and EEG were unremarkable.

Headaches:
Resolved.

Hypersensitivity of the skin in right arm, chest, abdomen and leg, etc. The cause is undetermined. He has been doing well. He sees Dr. Williams regarding this issue.

I previously discussed work-up and significance. I discussed the results of his cervical and thoracic spine MRIs and blood tests. I discussed ongoing symptomatic treatment, other options, referral to university center, etc.

He apparently has been diagnosed with fatty liver in the past.

DIFFERENTIAL DIAGNOSIS
Episode of unresponsiveness:
Single unprovoked seizure.
Single provoked seizure.

Syncope.
Stroke was not demonstrated.
CNS infection.
Metabolic encephalopathy.
Others.

Headaches:
Intracranial mass lesion was not demonstrated.

Hypersensitivity of the skin in right arm, chest, abdomen and leg, etc.
Intracranial pathology such as stroke or multiple sclerosis lesion were not demonstrated.
Myelopathy, radiculopathy, polyneuropathy, etc.

RECOMMENDATIONS

1. Patient will continue care with Ms. Saenz and Dr. Williams.

2. Please refer Mr. Carrillo back here if needed.

The patient and/or all parties present voiced understanding and agreement.

Thank you very much for allowing me to participate in this patient's care.

Sincerely yours,

Mario R. Aguilar MD

Mario R. Aguilar M.D., P.C.

*Electronically Signed on 01/26/2018 10:20:10.
Electronically Faxed to M. Saenz 647-1565 on 01/26/2018 at 10:24 am

Confidential

Exhibit TT

"Frankel, Harris A" <harris.frankel@unmc.edu>
02/19/2018 10:59 AM

To "jpholland@up.com" <jpholland@up.com>, "Deb A. Gengler" <DAGENGLE@UP.COM>
cc
bcc
Subject Medical reviews

This email originated from outside of the company. Please use discretion if opening attachments or clicking on links.

Attached are final drafts of the first 4 (I apologize for delay...everything now in place to be more efficient)

Redacted

I will affix evals to letter head for final submission and attach timesheet (10 hrs)

Redacted

I have done a preliminary review of Joseph Carrillo and **Redacted** time mutually beneficial

Thanks

H

Harris A. Frankel, MD

Senior Vice President and Chief Medical Officer

[IMAGE]

Nebraska Medicine

Kiewit Tower, First Floor

987400 Nebraska Medical Center

Omaha, NE 68198-7400

Phone: 402-552-2290

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e-mail: nidavis@nebraskamed.com

E-mail Confidentiality Disclaimer

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 - image001.png  Redacted

 Redacted

Exhibit UU

"Davis, Nikia S" <NiDavis@nebraskamed.com>
08/01/2018 11:56 AM

To "Theresa A. Rodino" <tarodino@up.com>
cc
bcc
Subject Case File Reviews

This email originated from outside of the company. Please use discretion if opening attachments or clicking on links.

Hello,

Attached are the reports we spoke of on the phone.

Have a great day!

Nikia S. Davis

Executive Assistant to:

Harris Frankel, MD, Chief Medical Officer

Frank Venuto, Chief Human Capital Officer

Executive Office

Nebraska Medicine
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 - Joseph Carrillo Report.pdf  **Redacted**

Union Pacific Railroad
Health and Medical Services

Exhibit VV

UNION PACIFIC RAILROAD - HEALTH & MEDICAL SERVICES
RESTRICTION REVIEW FORM

June 18, 2018

To: **Andreas Mader**

Daniel K. Glenn, Sr Supv Shop Ops

Regarding Employee: Joseph A. Carrillo
Employee ID: 00457172
Job Title or Craft: Electrician
Department: Mechanical
Service Unit: Sunset TSU
Work Location: EL PASO , TX

INSTRUCTIONS: Your employee is released to return to work with restrictions. Please review the outlined restrictions and respond to the questions below.
Restrictions & Accommodations: These work restrictions are to remain in place until June 2022, and then can be reassessed based on information from a current thorough medical evaluation (Health and Medical Services will advise the employee on what is needed for this evaluation).
****

Start Date	End Date	Description
06/18/2018	12/31/9999	Operation of Comp. Vehicles/On-Track or Mobile Equip./Forklifts -Prohibited
06/18/2018	12/31/9999	Operation of Cranes, Hoists, or Machinery - Prohibited
06/18/2018	12/31/9999	Work On or Near Moving Trains, Freight Cars or Locomotives - Prohibited
06/18/2018	12/31/9999	Work Requiring Critical Decision Making - Prohibited
06/18/2018	12/31/9999	Work at Unprotected Heights Over 4 Feet Above the Work Surface-Prohibited

These work restrictions are to remain in place until , and then can be reassessed based on information from a current thorough medical evaluation (Health and Medical Services will advise the employee on what is needed for this evaluation).

1) Do these restrictions interfere with the essential job functions? [X] YES [ ] NO

2) If yes, can reasonable accommodations be provided to allow the employee to perform the essential job functions?

[ ] YES [X] NO

3) If yes, how will the reasonable accommodation be provided?

[ ] Accessible Parking [ ] Assistive Technology [ ] Equipment
[ ] Job Reassignment [ ] Lift Assistance [ ] Modification of Job Duties

Union Pacific Railroad
Health and Medical Services

[ ] Modified Work Schedule [ ] Removal Of Non Essential Function
[ ] Tools [ ] Removal Of Architectural Barrier
[ ] Other (description required)

_____

_____

4) If no, please identify the specific reason(s) for the inability to return the employee to work or provide a reasonable accommodation for the outlined restrictions in relation to the employee's essential job functions?

[X] Accommodation would require removal of an essential function.
[ ] Accommodation would require lowering performance or production standard.
[ ] Accommodation violates the applicable collective bargaining agreement.
[ ] Other (description required)_____

_____
Supervisor Signature

_____ _____ _____
Supervisor Name Supervisor Title Date

_____
Manager Signature

_____ _____ _____
Manager Name Manager Title Date

_____
Director Signature

Andrea Myers _____ CMO Mesa Spine _____ 6/20/19 _____
Director Name Director Title Date

_____
Superintendent Signature

_____ _____ _____

Superintendent Name
Superintendent Title Date

A COPY OF THIS COMPLETED AND SIGNED DOCUMENT MUST BE FAXED TO HEALTH & MEDICAL SERVICES AT 402-501-0067 so a copy can be placed in the employee's personal medical record. This document may also be uploaded via the portal.

** Please use the bar coded cover sheet when faxing or uploading. Thank you.

** Please complete Form 16975 (see attached) if a Reasonable Accommodation is made.

Exhibit WW

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

- -

Joseph Carrillo, Case No. 3:21-cv-00026-FM

Plaintiff,

v.

Union Pacific Railroad Company,

Defendant.

- -

REMOTE DEPOSITION OF

ANDREAS MADER

DATE: November 18, 2021

TIME: 9:05 a.m. CST

PLACE: Veritext Virtual Videoconference

REPORTED BY: Jayne M. Seward, RPR

Job No: 4889286

* * APPEARANCES * *

On Behalf of the Plaintiff: (via videoconference):
James H. Kaster, Esquire
Nichols Kaster, PLLP
4700 IDS Center
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Minneapolis, Minnesota 55402
(612) 256-3200
kaster@nka.com

On Behalf of the Defendant: (via videoconference):
Katie M. Rhoten, Esquire
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St. Louis, Missouri 63141
(314) 338-3740
krhoten@constangy.com

I N D E X

WITNESS: ANDREAS MADER

EXAMINATION:
By Mr. Kaster: 4 - 53

EXHIBITS MARKED:
EXHIBIT 52: Restriction Review Form, 8-18-2018.....53
UPCARRILLO000614 - 616 - CONFIDENTIAL

PREVIOUSLY MARKED EXHIBITS REFERRED TO:
EXHIBIT 30: Locomotive Electrical Maintenance Technician/Diesel Electrician Job Description Brief
UPCARRILLO000071 - 73 - CONFIDENTIAL
EXHIBIT 34: Letter to Carrillo, 6-20-17
UPCARRILLO0000612 - CONFIDENTIAL

REPORTER'S NOTE: All quotations from exhibits are reflected in the manner in which they were read into the record and do not necessarily indicate an exact quote from the document.

P R O C E E D I N G S

ANDREAS MADER,
duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KASTER:
Q. Mr. Mader, have you been through a deposition before?
A. I have.
Q. Okay. On how many occasions?
A. Several.
Q. Okay. When's the last time, by the way?
A. Maybe a year or so ago.
Q. Okay. What kind of proceedings?
A. What was that one? That was the FMLA termination.
Q. Okay. So it was a --
A. Fraudulent --
THE REPORTER: I'm sorry. I'm sorry. We kind of talked over each other. Could you repeat your answer, sir?
THE WITNESS: It was for FMLA. We terminated for fraudulent use.
THE REPORTER: Thank you.
BY MR. KASTER:
Q. You terminated for what? I'm sorry.

A. Fraudulent FMLA use.
Q. Okay. So how many -- how many depositions do you think you've been through?
A. Call it half a dozen.
Q. Okay. Well, you know the drill, it sounds like. I'll be asking you some questions. I'll try to ask you simple, direct questions, if I'm capable of doing that. If I don't do that and I ask you a question that's confusing to you, ask me to repeat it and clarify. I'm happy to do that.
A. Okay.
Q. If you answer the question, I'm going to assume you understood it. So just let me know if that's an issue.
A. Absolutely.
Q. The second thing is I'd like you to say "yes" when you mean "yes" and "no" when you mean "no." Don't rely on "um-hum" or "huh-uh." If I hear you giving a slang answer that won't be well understood later on, I'm going to ask you to clarify it or repeat it.
The third thing, and the most important thing really, is that we can't talk at the same time. This is especially important in a virtual environment like today. I may think you're

completed with your answer and you're not. So if you're not, if I cut you off, that was inadvertent, and you should let me know that you have more to say on your answer. I'm happy to give you that opportunity.

The same is true on my side; if I'm in the middle of a question and you begin to answer, I will ask you to wait until the question is done before answering.

Are all those things understood to you?

A. Yes.

Q. Okay. You've been placed under oath here today. What does that mean to you?

A. I'm going to tell you the truth. I'm going to answer the questions truthfully.

Q. How long have you been employed by Union Pacific?

A. 2005, so 16 years.

Q. Okay. And what is your role there?

A. I'm currently the senior manager of shop operations.

Q. And how long have you been in this particular role?

A. Since last July.

Q. And tell me a little bit about your prior

roles that you've had with Union Pacific.

A. As I stated, in 2005 I joined on with Union Pacific. I started off as a OMT which is a management training program. I was in transportation in Chicago, so I was a transportation manager at the various yards in Chicago.

In 2016 I moved over to the Mechanical Department where I was the director of Mechanical Support. And in 2018 there was some reorganization and title changes. I went down to Fort Worth as a shop manager down in Fort Worth and that was 2018. And then in 2020 I came back up into Omaha.

Q. And what documents, if any, did you review in preparation for the deposition today?

A. I reviewed the documents that were -- with Katie yesterday.

Q. Okay. Do you recall what the documents were that you looked at?

A. I recall that there was a letter that I had previously sent out to Mr. Carrillo and -- what else did I review? A job description.

Q. Okay.

A. There were a couple of others. Maybe an email.

Q. What are your present duties in the role

that you have?

A. So I oversee the shop operations for our system mechanical facilities. I have my six direct reports who are out in the field, and we -- primarily we ensure that the shops are adequately staffed, trained and compliant with the company policies and regulatory compliance.

Q. How much did you work with Joseph Carrillo?

A. None.

Q. You didn't work with him at all?

A. No.

Q. What was the role that you had with Mr. -- at the time of these events Mr. Carrillo was taken out of service, say, 2018, 2019, 2017, in that time frame; what was your job at that time?

A. 2016, 2017 through -- through, like I said, it would have been, like, November 2018 when I went down to Fort Worth. So from 2016 through November of 2018 I would have been the director of Mechanical Support.

Q. So you never worked with Mr. Carrillo at all?

A. No.

Q. Did you have any information about his

work habits or --

A. His work habits, no.

Q. You don't know if he was a good worker or not a good worker; you don't know?

A. No, sir.

Q. He was a diesel electrician.

Did you ever oversee the work of diesel electricians?

A. Yes and no. So how I do explain that? Do I oversee their day-to-day activities? No. Do I screen and hire them and know what their responsibilities are? Yes.

Q. You don't really appreciate or understand the day-to-day job duties of a diesel electrician in the sense of what they're physically doing in given shops I take it?

MS. RHOTEN: I'm going to object to the extent that misstates his testimony. You can answer, Andy.

THE WITNESS: No. I understand the -- what their -- their functions are. I don't -- I don't sit there and -- so to clarify, I understand what their job is. I don't understand, like, the troubleshooting, like, as an electrician what he's looking for when he's looking for voltages or

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something of that nature.
Does that help clarify that for you?
BY MR. KASTER:
Q. Well, I'm going to dig a little into what -- have you ever watched them work?
A. Yes.
Q. Okay. Do you know -- first of all, do you know whether or not Mr. Carrillo worked in the shop or in the yard?
A. Well, he would have worked at El Paso so that's more of a servicing facility. They do have the shop there. He would have worked in and out of the shop.
Q. Do you know if he worked out of the shop at all?
A. If he worked out of the shop?
Q. Do you know if he ever worked outside of the shop, or all of the work that he did was inside of the shop?
A. Oh, no, I wouldn't know that. I mean, we service locomotives at various locations in the shop.
Q. Do you know whether he had fall protection for any work that he would do? There would be fall protection in the shop, right?

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MS. RHOTEN: I'm going to make an objection, form. You can answer, Andy.
THE WITNESS: Yeah, shops have fall protection.
BY MR. KASTER:
Q. And so his shop would have had fall protection?
A. Yes.
Q. Do you know how many times during a day he would actually have to climb anything to do work?
A. No.
Q. Did you ever ask him that question?
A. No. I never spoke to Mr. Carrillo.
Q. You've never talked to him at all?
A. No.
Q. You don't know him from Adam?
A. No.
Q. Did you ever speak to anybody who worked with him on a regular basis?
A. Not that I can recall.
Q. What's your educational background, by the way?
A. I have an MBA and a JD.
Q. You do, huh?
A. I do.

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Q. Good for you. So --
A. I'm using it.
Q. Well, I think maybe, like a lot of my classmates, you are using it.
So do you have any training in occupational health by the way?
A. How do you mean?
Q. Well, I don't know. It's right here on my outline so I'm asking you the question.
A. I'm not an occupational health nurse, so...
Q. Yeah. Have you received any training at Union Pacific in, you know, how to work with somebody in a situation where there might be some restrictions on their ability to do their job?
A. Not that I can think of anything particular that, you know, we say if this is a restriction and this is an accommodation. I mean, we review ADA, you know, like, on an annual basis with EEOC training and things of that nature.
Q. Where did you work prior to the time that you came to Union Pacific by the way?
A. I was in the military.
Q. Okay. And what did you do in the military?

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A. Well, I was in the military for 20 years. I did a lot. I --
Q. You did whatever you were told, right?
A. I -- you know, I was engaged in operations is primarily what I did.
Q. What branch were you in, by the way?
A. In the Navy.
Q. Yeah. So did you receive any specific training when you were in the Navy? I know the answer to that is yes, but can you give us kind of a 10,000-foot view of that?
A. What training I received in the Navy?
Q. Yeah, as it would relate to issues that might be occupational in nature. Any?
A. I can't recall.
Q. You worked in El Paso for a time. Did I get that right?
A. I never worked in El Paso.
Q. Oh, you never worked in El Paso. Have you been there?
A. I've been to El Paso.
Q. How many times once?
A. Once or twice.
Q. For how many days in total? Do you know?
A. Maybe two, three days at a time.

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Q. For what purpose? Do you recall?
A. Investigations or training.
Q. What kind of investigations?
A. Disciplinary, industrial workplace investigations.
Q. So tell me what your role was in that respect.
A. Hearing officer.
Q. You were a hearing officer.
How long have you served in the capacity as a hearing officer?
A. That's kind of a requirement. You know, all managers have that capability of being a hearing officer. I've held them since I've been with Union Pacific in Chicago and here in mechanical.
Q. A disciplinary hearing is a hearing where the employee involved is brought in on some kind of a charge of misconduct, right?
A. Or a rules violation.
Q. Or a rules violation. And oftentimes those disciplinary hearings can involve discipline up to and including termination, right?
A. Correct.
Q. How many of those disciplinary hearings have you been involved in as a hearing officer?

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A. Over 100.
Q. On how many occasions have you ruled in favor of the employee by the way?
A. So I do not -- it's not a ruling in favor of the employee. It's either I sustain the charges or the charges are not sustained, and that's based upon the evidence. I wouldn't -- I don't keep track of how many times. Has there been times? Yes. Do I know --
Q. Do you know if it's less than 10, less than 10 times that you've not sustained the charges?
A. I'd be guessing if I gave you an answer.
Q. You don't recall?
A. No.
Q. The employee involved doesn't have the right to an outside third-party independent hearing officer, right?
A. No. That's by the collective bargaining agreement.
Q. Sure. I understand.
The employee can't subpoena witnesses to the hearing, right?
A. They can present witnesses on their behalf, yes, they can.
Q. Okay. But they can't -- they don't have

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the right of subpoena?
A. No.
Q. And if witnesses appear for them, they don't get paid, right; they don't get paid for their time?
A. So it would be at the organization's cost, not at the carrier's cost.
Q. And if an employee appears for Union Pacific, they do get paid, right?
A. It would be -- yeah, it would be on company time, correct.
Q. Witnesses are not actually placed under oath, right?
A. No.
Q. And the hearing itself, the employee doesn't have a right to a lawyer, right?
A. Correct. That is correct. They have right to representation, again, by the collective bargaining agreement.
Q. By virtue of a union rep?
A. Correct.
Q. So why is it -- just out of curiosity, it sounds like you've spent a lot of time in hearings as a hearing officer.
Would that be a fair statement?

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A. Yes.
Q. Why? I mean, what is it about your role that would cause you to be that hearing officer? Is it your educational background, is it -- do you have a viewpoint on that?
A. I mean, I can only guess it's when I came to the Mechanical Department, they were looking at having one person hold a majority of the hearings, and coming from Transportation I did hold hearings. So maybe that was an influence upon them on why they selected me for that position.
Q. When you say "coming from Transportation, you did hold hearings," tell me about that.
A. How so? What do you mean, tell you about them?
Q. Well, what I mean is so you had worked in the Transportation Department is what you -- I think is what you're saying, right?
A. Correct. Out of Chicago, yes.
Q. And so had you spent a lot of time while you were working in the Transportation Department holding these hearings?
A. I held several, yeah. I mean, it all depended. You know, it's -- it's not like we're doing them every day. You know, it's -- as you said

earlier, it's about rules infractions or policy violations. So, I mean, yeah, I held my fair share. Again, I wouldn't be able to give you a number but I've held, you know, more than 12 throughout that time.

Q. So these hearings, how many hours or days did they last typically?

MS. RHOTEN: I object to the line of questioning on the grounds of relevance. I don't really see how this pertains to Mr. Carrillo specifically because there is no hearing at issue for which Andy is testifying. But, Andy, you can answer to best of your ability.

THE WITNESS: I mean, it varies. You know, if I've held it in absentia because the employee doesn't show up, it could go an hour, hour and a half. I've had some that have lasted, you know, seven hours.

BY MR. KASTER:

Q. So you went from the Transportation Department to what department are you in today then?

A. Mechanical.

Q. Mechanical. And that transition happened when?

A. 2016.

Q. And how would you describe the overarching responsibilities of the Mechanical Department?

A. Mechanical Department is we're here to service and repair locomotives.

Q. You looked at the job description for a diesel electrician in advance of your deposition. Did I get that right?

A. Yes.

Q. Have you seen that before?

A. Yes.

Q. When was the first time you saw it?

A. I can't tell you. I don't know when the first time I saw that was.

Q. Have you ever supervised -- first of all, you've never worked as a diesel electrician, right?

A. Correct.

Q. You don't have any training as an electrician?

A. So do I have electrical training? Yes. But am I an electrician as a journeyman? No.

Q. Have you ever worked as an electrician for Union Pacific Railroad?

A. No.

Q. You don't have any certifications or education in being an electrician, right?

A. Correct.

Q. So other than possibly fixing a loose wire at home, do you have any specific background in the work of an electrician?

MS. RHOTEN: I'm going to object to form. You can answer, Andy.

THE WITNESS: Well, again, do I understand what their job responsibilities are? Yes, I do. I understand what an electrician does.

BY MR. KASTER:

Q. Do you know what the duties of an electrician are?

Say, Mr. Carrillo, do you know what duties he had in the field?

A. I'm not understanding what you mean by "in the field"?

Q. Well, I mean outside of the shop.

MS. RHOTEN: Are you asking what his duties would have been at the El Paso facility as a diesel electrician?

MR. KASTER: I'm okay with my question as it is.

THE WITNESS: I'm not sure how to answer that because I'm not understanding the question.

BY MR. KASTER:

Q. Okay. When he stepped outside of the shop, if he ever did, do you know what, if anything, he did?

A. Well, I don't know if he's ever worked outside of the shop, so that's --

Q. Okay. So the answer is you have no idea?

MS. RHOTEN: Objection.

THE WITNESS: No, I wouldn't say -- that's not my answer because it depends. I've supervised -- like I say, I understand the responsibilities of a road electrician as well, but I don't know if Mr. Carrillo ever held one of those responsibilities. So what he particularly was dispatched to, I don't know.

BY MR. KASTER:

Q. Do you know if he ever worked on or near the tracks?

A. Yes, he would have had to.

Q. Because?

A. He works on locomotives and locomotives are on the track.

Q. Okay. That would be true even in the shop, right?

A. Right, yes.

Q. Okay. Do you know what duties, if any, he

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had on tracks that might have been outside the shop?
A. No, I don't know what his -- what jobs he held outside of the shop.
Q. Do you know how close he ever got to the tracks to do his work?
A. Inside the shop, outside the shop, anywhere outside?
Q. Well, since you don't know about anything he ever did outside the shop, let's stay inside the shop.
A. Okay.
MS. RHOTEN: I'm going to object to form. You can answer, Andy.
THE WITNESS: Yeah, so I mean -- again, the locomotives are on the track, so you're going to be within a foot, two foot of the track when you're working on there. It depends. If you're working on something underneath, you could be in between the tracks, you know, because you've got your service track, you've got the rails above; you're working underneath there.
So there's a lot of variables. It's not, you know, just one type of answer. It depends where you're working at. If you're changing a light bulb, you're standing right in front of the locomotive in

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between the rail.
BY MR. KASTER:
Q. Do you know if he ever had to climb on top of a car to do work?
A. A railcar?
Q. A train car, a railcar, any car.
A. A railcar or a locomotive?
Q. A locomotive or a railcar.
A. And so --
Q. Either one.
A. As a -- in the Mechanical Department they would not work on railcars. They would just be working on locomotives.
Q. Okay.
A. Okay. So how -- how many times would he have had to have gotten on top of a locomotive?
Q. Right.
A. I don't know. It depends on what task he would be assigned.
Q. Do you know if he ever had to get on top of a locomotive to do work?
A. I don't know.
Q. Do you know whether or not he had any duties or responsibilities as it related to moving trains?

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A. Moving trains, no. Moving locomotives, yes.
Q. Okay. As it related to moving a locomotive, what, if any, duties did he have?
A. All right. So at the El Paso locomotive facility, all the employees there are locomotive mover certified. They are all responsible for being able to move the locomotives in and out of the shop and to spot them.
Q. And what actually happens when an employee moves a locomotive?
First of all, have you done it?
A. Well, I was a -- yes, I have moved locomotives.
Q. Okay. What actually happens when you move a locomotive?
A. Are you asking the process of moving a locomotive?
Q. Sure. Who does what?
A. All right. Well, typically there's two people when you're moving a locomotive. You have a ground person and you have an operator. The ground person would be giving hand signals and giving directions to the operator, and the oper- -- you know, throwing any switches or -- you know, for

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their intended route, whatever. And then the operator would be up in the cab, and he would be the one controlling the throttle and the brakes.
Q. And when you say throwing a switch, you're talking about a directional switch?
A. Correct, lining yourself into various tracks in the yard.
Q. And when you're in the cab -- first of all, is there any requirement for who's in what position, who's the flagger or signaller or who's the person in the cab?
A. You mean who would be the ground person or the operator?
Q. Right.
A. No, there's no rhyme or reason. They job brief that and discuss it among themselves.
Q. Okay. So they're essentially fungible; they're interchangeable parts? Joe can go up and get in the cab and move the locomotive, and Tom can be the flagger or -- and the next day they can flip around, right?
A. True, and we can also have single-man moving operations where it would be one person in the cab just moving the locomotive without a ground person.

Q. You can only go up to five miles an hour when you move the locomotive; that's the rule, right?
A. So the speed limit is five miles an hour. Can you exceed that? You can exceed the speed limit, not by rule, right, because if you -- you know, if you engage the throttle, it's just like stepping on your gas pedal. You put more gas, you're going to go faster.
So, yes, the speed limit inside the shop is five miles an hour, but, yes, you can exceed that speed limit.
Q. I take it that might be one of the things that would bring someone into a disciplinary hearing like the hearings that you held, right?
A. Correct.
Q. Exceeding the speed limit?
A. Correct.
Q. That would be a safety violation, right?
A. Yes.
Q. I assume there's a rule that's specifically on point that says don't do that?
A. There are several rules.
Q. There's lots of rules, right?
A. There are a lot.

Q. There's hundreds of rules, right?
A. Um-hum. True.
Q. All right. When you're in the cab, if you're moving the locomotive, say you're going two or three miles an hour and you want to stop, how do you stop?
A. You apply your independent brakes, if you're operating independently, you know, as a sole locomotive. Or your locomotive con- --
THE REPORTER: I'm sorry. "If your locomotive" something brakes?
THE WITNESS: Consist. You have two -- two brake systems on a locomotive, an independent brake and a -- what we refer to as the locomotive consist, and that's where you have locomotives together.
THE REPORTER: Thank you.
THE WITNESS: And when you're operating as a consist, you -- when you apply your -- the train line brakes, you're going to engage all the brakes on the consist versus an independent brake.
THE REPORTER: Thank you.
MS. RHOTEN: Can you spell "consist" for the court reporter, Andy, just --
THE WITNESS: Yeah.

MS. RHOTEN: -- so we have that correct for the transcript?
THE WITNESS: Yeah. Consist, C-O-N-S-I-S-T. The consist.
BY MR. KASTER:
Q. Did you -- what safety measures are built into the locomotive to prevent it from continuing if there is human error?
A. In the shop, none.
Q. Inside the locomotive itself what safety measures exist? Are there buttons, switches that prevent the locomotive from continuing in the event there is human error?
A. So if I engage the throttle, it will continue until it hits something.
Q. There is nothing that prevents the locomotive?
A. Not inside the shop area.
Q. Well, say outside of the shop.
A. So if you -- so if you're running on a main line, and this is outside of a electrician for this, but on a railroad main line you have to engage an alerter or something along that nature every so often. If the alerter is not acknowledged, then the train would go into suppression and it would stop,

but that's running out of on main line when your systems are tested and, you know, engaged.
In the shop you don't have that. What you have in the shop is nothing. So if you engage the throttle, it will continue until it hits something.
Q. Okay. So there's absolutely no stop mechanism like what you described when you're moving a locomotive inside a shop?
A. Correct.
Q. How many people worked with Mr. Carrillo? Do you know?
A. I would have to look back at that time frame. I know we had some layoffs around there. Right now I think our facility count in El Paso is six.
Q. How many times did Mr. Carrillo have to move a locomotive inside the shop where he was inside the cab? Do you know?
A. No.
Q. Do you have any idea?
A. No. I just know that it would be a requirement for him to be able to.
Q. You don't know how many times that actually happened?
A. No, sir.

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Q. You don't know how many times he might have been the person signaling, as opposed to the person inside the cab?
A. No.
Q. Do you know how many times, if at all, he ever climbed over four feet to do his job?
A. No, I wouldn't know.
Q. And you don't know if he ever had to get on top of a locomotive?
A. No, I don't.
Q. You do know that, if he ever had to get off the ground, he had fall protection?
A. Right. So the shops, again, do have the fall protection, and if you go above the -- you know, the four foot, you need to have the fall protection.
Q. And, in fact, that's one of those rules, right?
A. It is.
Q. That you have to wear the fall protection if you're over four feet?
A. Correct.
Q. Failure to do that would bring you into one of those disciplinary hearings like you have, right?

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A. Yes.
Q. Have you ever had any training on the Americans with Disabilities Act?
A. I mean, we have our annual training discussing, you know, the generalities of it, along with our EEOC training on how it matters.
Q. Would you consider yourself familiar with that act in the sense of understanding the different parts of the act, the different subdivisions of the law?
A. Not an expert.
Q. Other than the annual training that you have as it relates to EEO issues, any particular training on the ADA that you can recall?
A. Not that I can recall.
Q. I'm going to bring up a couple of exhibits, but I think --
A. I'm logged into that Exhibit Share, so --
Q. Okay. Well, I didn't because -- so I'm going to go share this on my screen.
A. Oh, okay.
Q. Okay.
A. So do I need Exhibit Share then now?
Q. You may or may not.
A. All right.

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Q. I don't think so.
A. All right.
THE REPORTER: Are we going to mark this as an exhibit, Mr. Kaster?
MR. KASTER: Yeah. I think it was previously marked, Jayne, but I don't know what number it is. It's the job description.
Katie, do you happen to know what number it is?
MS. RHOTEN: I can't remember off the top of my head because I know it was a continuation from Mr. Carrillo's deposition. I'm not sure where we pick up with the numbers.
MR. KASTER: Yeah, I know we're on -- what are we on today, Jayne?
THE REPORTER: 52.
MR. KASTER: Let's just call this 52. It's a job description for a diesel electrician.
(Exhibit 52 marked.)
BY MR. KASTER:
Q. Mr. Mader, you told me that you are familiar with the job description, right?
A. Yes. And I do have it up here on my screen.
Q. Okay. I'm looking at the essential job

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functions.
THE REPORTER: There's a number on it.
BY MR. KASTER:
Q. Did you have --
MS. RHOTEN: It looks like this is Exhibit 30. Sorry, James.
MR. KASTER: Oh, let's just call it 30 then, Katie. Thank you very much.
(Exhibit 52 withdrawn.)
BY MR. KASTER:
Q. Can you see what I'm looking at, Mr. Mader?
A. I have mine up on the screen. I'm not sure which part you're looking at right now though.
Q. Okay. Well, can you see the shared screen?
A. Yeah, where it says "Job Requirements: Read and Understand."
Q. Did you have this job description -- first of all, you were asked to consider whether or not Mr. Carrillo could be accommodated based upon the restrictions that he had been given, right? Am I right about that?
A. Yes.
Q. And who did you talk to for the purpose of

determining whether or not he could be accommodated with the restrictions that he had?

A. So I look at the restrictions that Health and Medical provided me, which I would have to look at those. I think that was an exhibit that had my letter that I had sent to Mr. Carrillo, which --

Q. Okay. Are you saying that you would prefer to look at that first? I've got it right here.

Well, let me ask the question to you differently. Would it be helpful for you to look at your letter?

A. I would look at them side by side, so...

Q. Okay.

A. All right. So do you want me to explain my process; is that what you're asking me?

Q. Yeah, please.

A. Okay. So I would get a notification, and it's the Restriction Review Form, which is something that Health and Medical would send, and it would come to me electronically through what we refer to as eHealthSafe.

I would then look over the restrictions that Health and Medical decided -- or were placed on the employee by Health and Medical. I would then

look at the job functions of the electrician and compare it against the restrictions that Health and Medical imposed on the employee and compare to see whether or not those -- what -- and what we -- what the restrictions were in looking at the essential job functions.

Does that answer that?

Q. Well, this is what I'm getting from your answer. This is what I think I'm hearing. I think I'm hearing that you don't remember this; is that right?

A. That I don't remember this? I mean, I did more than just Mr. Carrillo.

Q. You have no memory of actually doing the restriction review for Mr. Carrillo; am I right about that?

A. I remember being -- having that responsibility.

Q. You don't remember actually doing it?

A. Not that I recall. I mean, I remem- -- as I said, that was part of my job responsibility when I was the director of Mechanical Support where I would review. Mr. Carrillo wasn't the only one I had reviewed.

So I can't say that, yes, I remember

sitting down and reviewing Mr. Carrillo's restrictions. It was a process when I looked at the restrictions versus the essential job functions.

Q. I understand you recall the process. What I want to be clear about is you don't recall actually doing this review for Mr. Carrillo.

Am I right about that?

A. Yes.

Q. All right. Well, we'll take a look at a couple of other documents.

Well, let me ask you this: Do you remember if you spoke to anyone as a part of the restriction review process for Mr. Carrillo?

A. I believe I did.

Q. Do you remember who?

A. I think it was -- it might have been Voc Rehab.

Q. Do you remember who?

A. That would have been somebody in Voc Rehab. I don't know who was in that position back then.

Q. Do you have any notes of a conversation with anyone in Voc Rehab?

A. No, I don't have any notes.

Q. Did you speak to anybody in the El Paso

shop?

A. Not that I recall.

Q. Did you speak to anybody who actually worked with Mr. Carrillo?

A. Not that I recall.

Q. And you didn't speak to Mr. Carrillo?

A. No.

Q. How much time do you think you spent on this restriction review process for Mr. Carrillo?

A. Maybe 45 minutes.

Q. Maybe?

A. Maybe.

Q. And you have no recollection of what you actually did in terms of the review process?

A. So that would go to my process that, as I stated early, is that I would review the restrictions imposed and balance them up against the essential job functions.

So, I mean, it was standard whether it be Mr. Carrillo or Joe Smith. I mean, it was still the process that I followed. But to answer do I specifically remember doing it for Mr. Carrillo? No.

Q. All right. Well, I'm going to leave the job description and look at a different document

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here. Okay. So let's do this. All right. I don't believe this is marked? Am I correct, Katie, this?

MS. RHOTEN: I do not believe so. Unless it was used in one of the -- unless it was used in Dr. Holland's deposition yesterday, I don't believe it's been marked.

MR. KASTER: No. It wasn't used yesterday. So let's call this -- this will be 52 then.

(Exhibit 52 marked.)

BY MR. KASTER:

Q. And, Mr. Mader, I take it this is a document you looked at yesterday?

A. Yes. Yeah.

Q. And this is what you filled out during that 45 minutes?

A. Yeah, this would have been the document that I received through eHealthSafe.

THE REPORTER: Are there Bates stamps on this, Jim?

MR. KASTER: Oh, yeah. Sorry. Let's get that so that's clear. It's Bates stamps 614, 615 and 616.

THE REPORTER: Thank you.

BY MR. KASTER:

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Q. All right. So how did you know that Mr. Carrillo was an electrician?

A. It says it right there.

Q. Okay. You didn't have any conversations with anybody about what he actually did as an electrician? You relied on, I take it, the job description?

A. Yeah. I mean, yeah, the electricians across the system perform very similar tasks.

Q. Let's look at the restrictions themselves. Operation -- the first one is he's prohibited from "Operating Company Vehicles/On Track or Mobile Equipment/Forklifts."

I take it that would include the locomotive, right?

A. Yes, company vehicles, locomotives. If he were in a different facility, a car mover, which is a -- like a prime mover. It's something you would take on, but it's an on-track equipment. It could be a high-rail in engineering, but that's not applicable here. So, yeah. Yeah.

Q. You don't know, as we've discussed, how many times he actually operated a locomotive inside the shop, right?

A. No.

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Q. Did he operate any other on-track equipment besides the locomotive?

A. On-track equipment, no. The only on-track equipment would be a locomotive.

Q. The next one is: Operation of cranes, hoists or machinery is prohibited.

Do you know whether or not he operated cranes, hoists or machinery?

A. It depends on the task. But do I know specifically? No. If he operated one or how many times he's operated in the past? No. But, again, it's task-based. If they had to change out a generator, then he would have to use one.

Q. Do you know whether or not someone else could operate the crane, hoist or other machinery?

A. So I guess it would depend, right, on what the task was and how many people, because when we're looking at El Paso. I said there's six employees that worked there, I guess it would be possible.

Q. The next one says "Work On or Near Moving Trains, Freight Cars or Locomotives."

A. Okay.

Q. Do you know if he worked on or near moving trains?

A. He could. I don't know specifically if he

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did, but when you're in a train yard, there's trains because that's the nature of our industry. So if he was working out in the yard, you'd have moving trains.

Q. I take it that diesel electricians would actually work on a train or a locomotive inside the shop when the locomotive was stopped, right?

A. Right. So if a locomotive is being worked on, it would be in the shop.

Q. And it would be stopped?

A. On that particular track, yes.

Q. I mean, I take it that, if somebody was working on a locomotive, on the electrical part of a locomotive as it was rolling down the tracks, that might be one of those rule violations, right?

A. Possibly, possibly not. Like, if you were troubleshooting something, right? So, I mean, I couldn't say definitively.

Q. It's safe to say, though, that an electrician, a diesel electrician is typically working on a stopped train in the shop, right?

A. Yes. Yeah. So -- yeah. So the train -- so let me just clear up some -- some definitions, if you would.

A train is a complete cars and locomotive,

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okay, because we're using them interchangeably here. A train is a complete set. It's loco- -- a locomotive with cars attached. A locomotive being a singular or multiple locomotive in a consist.

Q. Okay. You said we're using them interchangeably. You really meant I was using them interchangeably, right?

A. Yes, yes. I just wanted to clarify so we're on the same page --

Q. Okay. I got it.

A. -- when you're using "train" and "locomotive."

Q. I hear you. I hear you. Okay. All right.

A. So in the shop, if you are working on a locomotive, yes, that -- that particular locomotive would be stopped.

Q. The next restriction here is "Work Requiring Critical Decision Making."

A. Okay.

Q. Do you know what jobs don't require critical decision making?

A. There's a lot of jobs that don't require critical decision making.

Q. Can you think of one?

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A. A janitor.

Q. Well, you know, I have many friends who are janitors who might argue with you about that.

A. So when used in reference to an electrician for Union Pacific, what we look at with the critical decision making aspect of that is testing and setting up things like Positive Train Control, coded cab signals, working with the TIR, the Track Image Recorder, the inward- and outward-facing cameras. Those are all those safety appliances.

Like you were referring to earlier, like, what stops a train, you know, in the shop, nothing. On the track, Positive Train Control, coded cab signals, those would stop a train on the main track. And that --

Q. Is there any definition -- go ahead. I didn't mean to cut you off. I thought you were done.

A. No, I was -- I'm done.

Q. Okay. Is there any definition anywhere of critical decision making?

A. Not that I'm aware of.

Q. Are there any jobs at Union Pacific that don't require critical decision making?

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A. So anything that doesn't impact safety. So a timekeeper or an admin who is processing timecards where there's no impact of safety to themselves or others, I would consider that, you know, a noncritical decision making position.

Q. Any management position that -- any management position at Union Pacific would be a job requiring critical decision making, right?

A. I would say so, yes.

Q. And it's probably fair to say that anybody working in maintenance on or around the tracks would require critical decision making, right?

A. Yes.

Q. So other than an admin who might be keeping track of time, can you think of another person, another job that didn't require critical decision making?

A. Not off the top of my head I can't think of anything.

Q. How many different jobs are there at Union Pacific?

A. I don't know. A lot.

Q. Hundreds. Hundreds, right?

A. A lot. I don't have a number.

Q. There's 40,000 employees at Union Pacific,

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right?

A. There's, like, 32,000 now.

Q. Wow. There used to be 40,000. What happened?

A. That would have been that reorg I talked about in 2018.

Q. I see. Is it fair to say this restriction, this prohibition would screen Mr. Carrillo out of the vast majority of those 32,000 jobs?

MS. RHOTEN: I object to form. You can answer, Andy.

THE WITNESS: Yeah. Honestly I couldn't say that.

BY MR. KASTER:

Q. Did you, yourself, consider whether or not there were other jobs that Mr. Carrillo could do?

A. Me personally? No.

Q. Do you know whether or not Mr. Carrillo was actually seeking to be reemployed or employed at Union Pacific on an ongoing basis at the time of the consideration of these restrictions?

A. Can you say that again, please?

Q. Do you know if he was looking for another position at Union Pacific at the time of your

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consideration of these restrictions?
MS. RHOTEN: I'm going to object again. It calls for speculation. You can answer, Andy.
THE WITNESS: Not that I'm aware of. And do you mind if I elaborate a second on this?
BY MR. KASTER:
Q. Go ahead.
A. All right. So with these restrictions, when you ask about other jobs, right, so, as you know, we're a unionized environment. When I look at these restrictions, I look at it as the electrician, right, because that was his current craft.
After I get done with the review, like in this case, where we could not accommodate, then I would send this over to Voc Rehab, and Voc Rehab would work and look for the other opportunities in Union Pacific.
Q. So it's not your job?
A. No, I wouldn't say that. That -- that -- that sounds kind of snarky, if you don't mind. But what I'm saying is I am looking at it as the -- as the requirements of an electrician in a Union Pacific shop in El Paso. That's because that is what he was hired on for, that is his -- his -- his agreement, his craft. That is his current job that

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he was, you know, employed as.
So, once I review that, then, like I said, Voc Rehab would look for those other opportunities. So that's like it wouldn't be my responsibility. Not not my job, but that's why we have that group to research and work with those particular restrictions and other job opportunities.
Q. Do you know what, if anything, they did?
A. No, I don't.
Q. The last restriction here -- let's go back to this critical decision making.
A. Okay.
Q. And I just want to be clear about this. Is there a definition somewhere of critical decision making at the Union Pacific Railroad, if you know?
A. Yeah, you already asked that. No, I don't know.
Q. Dr. Holland testified yesterday that this restriction is ambiguous.
Do you think it's ambiguous?
MS. RHOTEN: I'm going to object to form. You can answer, Andy.
THE WITNESS: Yes, because it -- it's ambiguous, but you have to look at it in the context of what we're referring to.

Page 48

So a critical decision making for an electrician would be different than a critical decision making for a dispatcher, right? I mean, they're both safety sensitive.
So, yes, I can agree where he would say it's -- it's ambiguous, but if there is that safety aspect to it, that's what I would consider with the critical decision making, the safety aspect of it.
BY MR. KASTER:
Q. The last restriction here is "Work at Unprotected Heights over 4 Feet Above the Work Surface."
A. Okay.
Q. Do you know whether or not Mr. Carrillo ever had to work at unprotected heights over four feet?
A. No.
Q. You don't know what, if anything, Mr. Carrillo suggested about whether he could work with these restrictions or not?
A. I'm sorry. Say that again, sir.
Q. Do you know what, if anything, Mr. Carrillo said in response to these restrictions?
A. I never spoke to Mr. Carrillo.
Q. And you don't know about his conversations

Page 49

with anybody within the fitness-for-duty process or within Voc Rehab, right?
A. No, sir.
Q. You don't know what, if any, accommodations were considered beyond the 45 minutes that you spent on this, right?
A. Say that again.
Q. You don't know what, if anything, happened with respect to the restrictions or considerations of whether or not Mr. Carrillo could do this job or other jobs at Union Pacific beyond that 45-minute window of time?
MS. RHOTEN: I'm going to object to form. You can answer, Andy.
THE WITNESS: Yeah, what do you mean by "other jobs"?
BY MR. KASTER:
Q. Do you know whether or not there was consideration for other job opportunities for Mr. Carrillo?
A. No. That would have been Voc Rehab.
Q. That's what I'm trying to establish is: Beyond this 45-minute window, you had no contact with anything related to Mr. Carrillo, right?
A. Yes, sir. That's correct.

Q. And we've covered this, but you've never talked to Mr. Carrillo or anybody who worked with him, right?
A. I've talked with them. Did I talk to them about Mr. Carrillo? No, not that I recall. So have I talked with the people in the shop over in El Paso? Yes. Did I ever specifically talk about Mr. Carrillo? Not that I recall.
Q. I'm going to bring up this last document just so we're clear. I think this is the letter that you sent.
A. Okay.
THE REPORTER: A new exhibit, Mr. Kaster?
MR. KASTER: Yes, and I'll be right there.
THE REPORTER: And that will be 53.
(Exhibit 53 marked.)
BY MR. KASTER:
Q. Do you see a letter of June 20th, 2018, to Mr. Carrillo?
A. Yes.
MR. KASTER: And so we're clear about this, this was previously marked as Exhibit 34. So sorry, Jayne, I didn't see that sticker at the bottom there.
THE REPORTER: I'll just say we didn't

mark it. And we'll use 34 you said?
MR. KASTER: Yes.
(Exhibit 53 withdrawn.)
BY MR. KASTER:
Q. Is says "This is to advise you" -- and we've -- so there's a repeat at the beginning of the letter of the restrictions that we just looked at, right?
A. Yes, sir.
Q. And then it says in bold caps, or in bold letters rather, bold typeface, "This Is To Advise You That These Permanent Restrictions Cannot Be Accommodated By Your Supervisor," right?
A. Yes.
Q. A supervisor that you never talked to as a part of this process, right?
A. Well, no. I mean, being a manager for Union Pacific and having responsibility to look at and review the permanent restrictions, that's me.
Q. Oh, so you're the supervisor?
A. Yeah. I mean, I'm using that as a general term. I'm not saying specifically that Roddy in El Paso said that he couldn't accommodate that. Me being a manager for Union Pacific and having responsibility for reviewing things.

Q. Okay. Because you never talked to Roddy in El Paso about Mr. Carrillo, right?
A. No, not that I recall.
Q. So when you're saying "This is to advise you that these permanent restrictions cannot be accommodated by your supervisor," "your supervisor" is you?
A. Yes.
Q. Do you often refer to yourself in the third person, by the way?
A. No. I mean, it's a form letter.
Q. So back to my question: Do you often refer to yourself in the third person?
MS. RHOTEN: I'm going to --
THE WITNESS: No.
MS. RHOTEN: -- object. You can answer, Andy.
THE WITNESS: No.
BY MR. KASTER:
Q. This is Exhibit 34, and what you're saying, what I think I hear you saying, Mr. Mader, is that this is a form letter.
A. Yes.
Q. So you didn't write these words; somebody else wrote the words?

A. Well, yes. I mean, I drafted this based off of the form letter that we had used at the time.
Q. Okay. But the form letter that you used at the time would probably be all filled out except for possibly these specific restrictions and Mr. Carrillo's name, right?
A. Yes.
MR. KASTER: I think that's all the questions I have for you today, Mr. Mader. Thank you.
THE WITNESS: Thank you.
MS. RHOTEN: Nothing from us. Jayne, we're going to read and sign. And then we'll do PDF condensed and full size of the transcript with exhibits, please.
MR. KASTER: Okay. Thank very much.
THE WITNESS: Thank you all. Have a wonderful day.
MS. RHOTEN: Thanks, Andy. Thanks, Jayne.
(WHEREUPON, the deposition of ANDREAS MADER was concluded at 10:12 a.m.)
***

REPORTER'S CERTIFICATE

STATE OF MINNESOTA)
)SS.
COUNTY OF HENNEPIN)

I hereby certify that I reported the remote deposition of ANDREAS MADER on November 18, 2021, via Veritext Virtual Videoconference, and that the witness was by me first duly sworn to tell the whole truth;

That the testimony was transcribed by me and is a true record of the testimony of the witness;

That the cost of the original has been charged to the party who noticed the deposition, and that all parties who ordered copies have been charged at the same rate for such copies;

That I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel;

That I am not financially interested in the action and have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect my impartiality;

That the right to read and sign the deposition by the witness was not waived.

WITNESS MY HAND AND SEAL this 24th day of November, 2021.

Jayne M. Seward
Notary Public, Hennepin County, Minnesota
My commission expires January 31, 2025

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

November 29, 2021

To: Mr. Ortbals

Case Name: Carrillo, Joseph v. Union Pacific Railroad Company

Veritext Reference Number: 4889286

Witness: Andreas Mader Deposition Date: 11/18/2021

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4889286
CASE NAME: Carrillo, Joseph v. Union Pacific Railroad Company
DATE OF DEPOSITION: 11/18/2021
WITNESS' NAME: Andreas Mader
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Andreas Mader

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4889286
CASE NAME: Carrillo, Joseph v. Union Pacific Railroad Company
DATE OF DEPOSITION: 11/18/2021
WITNESS' NAME: Andreas Mader
In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.
I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).
I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Andreas Mader

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:
They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.
I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 4889286
PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Andreas Mader
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20_____ .

_____
Notary Public

_____
Commission Expiration Date

Exhibit XX

BUILDING AMERICA®

US CERTIFIED MAIL
RETURN RECEIPT ELECTRONIC

June 20, 2018

Joseph Carrillo
0457172

3013 Zacatecas Ct
Las Cruces, NM 88012

Dear Mr. Carrillo:

Health & Medical Services has advised the Mechanical Department, based on medical documentation available to Union Pacific Railroad, that you have been released to return to work with the following permanent restrictions:

- Operation of Comp. Vehicles/On-Track or Mobile Equip./Forklifts -Prohibited
- Operation of Cranes, Hoists, or Machinery - Prohibited
- Work On or Near Moving Trains, Freight Cars or Locomotives - Prohibited
- Work Requiring Critical Decision Making - Prohibited
- Work at Unprotected Heights Over 4 Feet Above the Work Surface - Prohibited

This is to advise you that these permanent restrictions cannot be accommodated by your supervisor.

Depending on the circumstances, the following options are available to you:
- You may exercise your seniority in accordance with your respective agreement;
- Your case can be reviewed by Health & Medical Services, and a referral made to Disability Prevention Management for potential vocational opportunities; or
- You may choose to seek Railroad Retirement benefits.

If updated medical information is received, Heath & Medical Services will be able to review the information and issue another fitness-for-duty decision. Please contact Health & Medical Services at (877) 275-8747 to initiate a Fitness for Duty review. If you will be applying for Railroad Retirement benefits, I suggest you take a copy of this letter with you.

If you have any other questions regarding the medical review process, please contact Health & Medical Services at (877) 275-8747, Option 4.

Andreas Mader

CC:
- Dan Glenn, E-mailed
- Roddy Rodriguez, Emailed
- Bridgette Ziemer, E-mailed
- Pauline Weatherford, E-mailed
- EHEALTHSAFE, E-mailed

Exhibit YY

COLLEGE OF MEDICINE
Department of Neurological Sciences

T. Scott Diesing , M.D.
988440 Nebraska Medical Center
Omaha, NE 68198-8440
402-559-9953

12/1/2021

Mr. Robert Ortbals, Jr
Constangy, Brooks, Smith, & Prophete LLP
680 Craig Road
Suite 400
St. Louis, MO 63141

Re: Mr. Joseph Carrillo

Dear Mr. Ortbals,

I have reviewed the provided documents related to Mr. Carrillo and the Union Pacific Railroad Company. The reviewed records include: Plaintiff's Complaint; Protective Order entered by the Court; Electronic Technician Job Description Brief (dated 05/2009) (UPCARRILLO000071-73); Union Pacific Medical Comments History re: Joseph Carrillo (UPCARRILLO000074- 102); Union Pacific Medical File re: Joseph Carrillo (UPCARRILLO000103-647); Carrillo's Medical Records from Mountain View LCPS (UPCARRILLO001373-1385); Carrillo's Medical Records from New Mexico Cardiac Care (UPCARRILLO001386- 1465); Carrillo's Medical Records from Sun View Imaging (UPCARRILLO001466-1471); Carrillo's Medical Records from Valencia Health and Wellness (UPCARRILLO001472- 001526); and Expert report prepared by Dr. Michael Devereaux, M.D., F.A.C.P.

As you are aware, I have no physician-patient, personal, or professional relationship with Mr. Carrillo. I have not personally examined nor taken a medical history from Mr. Carrillo.

University of Nebraska Medical Center

Summary of the reviewed records

Mr. Carrillo suffered a loss of consciousness on or around June 27, 2017. At the time he was a 31-year-old diesel electrician employed by Union Pacific Railroad. He had reportedly been feeling ill with some "flu-like symptoms" for the previous 4 days. He had also stopped taking his medication including gabapentin 800mg BID for the same period. On a particular morning in late June 2017, he awoke for work. Mr. Carrillo reported to multiple providers that he had taken a shower and brushed his teeth. The next thing he recalls is waking on the floor. He was not incontinent of bowel or bladder. He reported that he was "very confused", had a headache and nausea soon after waking. He also reported an injury to his tongue. He has no recollection of the actual event itself.

His wife was not present at the onset of the event per documentation by the primary care provider (PCP) Mia Saenz APRN who was the first provider to speak with him days after the event. Nor was she present at the onset per the documentation of the neurologist, Dr. Aguilar. The history obtained by the treating neurologist Dr. Aguilar and the PCP states that his spouse heard him snoring and went into the room to check on him. She found him lying on the floor. When she found him, he was breathing slowly and snoring. There was shaking of his arms, shoulders and trunk followed by limpness. She as well reported a lateral tongue injury. She reported the loss or consciousness lasting at least 5 minutes. The reports state that she was not present at the onset. Therefore, the total duration of the event is not known, nor what happened prior to her finding Mr. Carrillo. Notably, Mr. Carrillo, Mia Saenz NP, and Dr. Aguilar all note a right lateral predominant tongue bite. At no point is there evidence in any of the examining providers notes of external trauma, closed head injury, or craniofacial injury.

Mr. Carrillo described a number of other symptoms subsequent to the event in question. He complained of a novel headache following the event which persisted for at least several months. To Dr. Aguilar he consistently reported hypersensitive skin on the right side along with numbness of the back of his right thigh. He also reported memory difficulties. He may have also continued to have some nausea and diarrhea.

Mr. Carrillo was evaluated by a neurologist, Dr. Aguilar and cardiologist, Dr. Motta. The evaluation included but was not limited to a negative or normal EEG, MRI brain with and without contrast, electrocardiogram, trans thoracic echocardiogram, carotid artery ultrasound, cardiac stress test, and Holter monitor. The cardiologist Dr. Motta lists "syncope, unspecified syncope type" as a presumptive diagnosis but there is no documented follow up. The treating neurologist, Dr. Aguilar continuously lists the impression as "an episode of unresponsiveness" and a list of possible etiologies beginning with a seizure. Dr. Aguilar lists this as the first possible differential diagnosis in both of the first two notes, and goes on to recommend typical seizure precautions including restrictions from driving, ladders, etc. Drs. Holland and Frankel have reviewed the case and associated documents, and both have found the etiology to be most consistent with a seizure and recommended appropriate precautions. Dr. Devereaux reviewed the records as well but did not examine the patient. He did question Mr. Carrillo 4 years after the event and admits that the diagnosis is that of an episode of transient loss of consciousness of unknown etiology. He goes on to state that even if it were a seizure, 20% of patients would not present with a second seizure in the subsequent 2 years. Thus Dr. Devereaux does not exclude the diagnosis of seizure.

As part of my review, I have been asked to answer the following questions:

1. Explain the nature of Joseph Carrillo's condition and diagnosis. Was it medically reasonable for Union Pacific to conclude that Carrillo most likely lost consciousness due to a single unprovoked seizure?

   Mr. Carrillo's diagnosis is that of a transient loss of consciousness. It is clear and agreed upon by all the evaluating providers that he unpredictably and acutely was suddenly incapacitated, unresponsive, and unconscious. The definitive etiology of his event cannot be conclusively determined at this time. However, two neurologists, both Dr. Frankel and I feel reasonably confident that the event was most likely an unprovoked epileptic seizure. The treating neurologist Dr. Aguilar treated Mr. Carrillo as though he may have had a seizure by recommending standard seizure precautions such as refrain from driving. Dr. Devereaux does not share that confidence, but states that it could have been a seizure. Based on the preponderance of evidence and medical opinions was medically reasonable for Union Pacific to conclude that Mr. Carrillo most likely lost consciousness due to single unprovoked seizure.

2. What neurological complications or issues are associated with Mr. Carrillo's condition? Why?

   The neurological complications or issues associated with both an epileptic seizure or syncope include a sudden incapacitation to the effect of losing responsiveness and control of one's own body. This has implications when the patient is sometimes involved in safety sensitive or vulnerable activities. There is a known risk of recurrent seizures following a single unprovoked seizure. The rate of second seizure after an unprovoked seizure has been shown to be 29% at 3 years (Hauser et al, Neurology, 1990) and 33% at 5 years (Hauser et al, NEJM, 1998). The risk of a second unprovoked seizure following a first seizure and following a negative comprehensive neurologic evaluation cannot be reduced without the passage of time. At the time of initial evaluation, there is little way to predict exactly which patient will go on to have a second seizure.

3. Does the guidance from the FMCSA regarding fitness-for-duty for commercial motor vehicle drivers (including guidance from the FMCSA Medical Expert Panels, Medical Review Board, and Medical Examiner Handbook) provide a reasonable evidence-based assessment of risks for sudden incapacitation relating to specific health conditions such as, for example, seizures?

   Yes, Page 137 of the FMCSA Medical Examiner Handbook in the section titled Risk from Seizures and Epilepsy explains that the safety of the driver and the public are the major reasons for restricting a person from commercial driving. Page 148 of the Handbook under

the section Single Unprovoked Seizure, paragraph 2 states "The overall rate occurrence is estimated to be 36% within the first 5years following the seizure. After 5 years, the risk for recurrence is down to 2% to 3% per year for the total group." These assessments are similar to the evidence-based literature cited elsewhere in this report.

4. Are the conclusions and recommendations of the FMCSA guidance consistent with the best evidence from the scientific literature on these topics?

   Yes, (See response #2)

5. For conditions/diagnoses like Mr. Carrillo suffered, what does the FMCSA guidance provide with regard to restricting such person from operating a motor vehicle?

   Yes. Page 148 of the FMCSA Handbook addresses this specific condition under the section Single Unprovoked Seizure. Paragraph 3 states "Following an initial unprovoked seizure, the driver should be seizure free and off anticonvulsant medication for at least 5 years to distinguish between a medical history of a single unprovoked seizure and epilepsy."

   As previously stated, the definitive etiology is not confirmed. The other etiology suggested by Dr. Devereaux has been syncope. Page 103 of the FMCSA Handbook under the section Syncope, states that "Syncope is a symptom, not a medical condition..." The Handbook provides multiple areas of guidance for restrictions based specific causes of syncope. However, none directly apply to Mr. Carrillo's case since syncope due to a specific cause was never diagnosed. In the absence of more specific recommendations or when multiple conditions may apply, the FMCSA Handbook advises on page 148 "Note: that "If more than one waiting period applies ... examine the driver for certification after the completion of the longest waiting period."

6. In applying the FMCSA medical guidance, how long would Mr. Carrillo be at risk for sudden incapacitation? What is considered sudden incapacitation and how much greater is Mr. Carrillo's risk for sudden incapacitation than the average population?

   The rate of second seizure after an unprovoked seizure has been shown to be 29% at 3 years (Hauser et al, Neurology, 1990) and 33% at 5 years (Hauser et al, NEJM, 1998). Sudden incapacitation is an abrupt loss or impairment of consciousness, control, or performance (Hastings et al, Occupational Medicine, 2002:17(2):197-209). Sudden incapacitation may be due to loss of motor control, vision, coordination, or consciousness as

a result of a seizure. The risk of unprovoked epileptic seizures in the general population ranges from 0.04% to 0.06% per year (Hauser et al, Epilepsia, 2008:49(S1):8-12).

7. Is it reasonable for Union Pacific to apply the FMCSA medical guidance in determining if an individual can safely perform a safety-sensitive position at Union Pacific that involved moving locomotives, such as the position held by Mr. Carrillo even though the position didn't involve operating a commercial motor vehicle?

   Yes, The FMCSA was established in 1999 by the United States government and is part of the U.S. Department of Transportation. The FMCSA created guidance for determining medical fitness and safety for commercial drivers in the trucking industry. It is reasonable to apply this guidance to persons working in safety-critical positions in the railroad industry.

8. Did Union Pacific correctly apply the FMCSA medical guidance for the type of condition/diagnosis from which Mr. Carrillo suffered?

   Yes. Mr. Carrillo suffered an unpredicted and sudden incapacitation that was more likely than not due to a single unprovoked epileptic seizure. Page 148 of the FMCSA Handbook addresses this specific condition under the section Single Unprovoked Seizure. Paragraph 3 states "Following an initial unprovoked seizure, the driver should be seizure free and off anticonvulsant medication for at least 5 years to distinguish between a medical history of a single unprovoked seizure and epilepsy."

9. Was it medically reasonable for Union Pacific to rely on the medical file review conducted by Dr. Harris Frankel?

   Yes. Dr. Frankel is a board-certified neurologist. I reviewed his report of 5/19/18 and found it to be accurate.

10. Do you have an opinion to a reasonable degree of medical certainty based on your education and experience as to whether Union Pacific was reasonable in placing the restrictions on Mr. Carrillo that it did for a period of 5 years? What is that opinion?

    Yes, I believe it was very reasonable for Union Pacific to place the restrictions on Mr. Carrillo for a period of 5 years. Mr. Carrillo suffered an unpredicted loss of consciousness one morning in late June 20217. He was found unresponsive with some shaking of the torso and

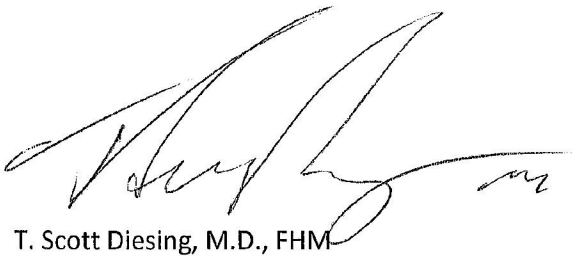
bilateral upper extremities. He suffered an injury to the right lateral tongue as a result of the event. Mr. Carrillo did not make a full and rapid return to normal after the event. A subsequent comprehensive neurologic and cardiologic evaluation did not result in a certain diagnosis. These salient facts are not in dispute and have been corroborated in combination by all providers that have evaluated Mr. Carrillo or the records, including Dr. Devereaux. The agreed upon uncertainties include the onset and duration of the event, what the shaking was, and most essentially the definitive cause of his loss of consciousness.

Dr. Devereaux's opinions as listed in his report of 10/21/21 are that Mr. Carrillo more likely had a syncopal event rather than a seizure. Three other physicians have reviewed the same records, and all independently concluded that a seizure is the most likely diagnosis. Dr. Devereaux opines that the available evidence "more strongly supports" the possibility of a syncopal event and refers to a telephone interview of the Carrillos 4 years after the event, and long after legal action has been initiated. I agree with Dr. Devereaux's comments on the reduced reliability of obtained history as time passes and would apply Dr. Devereaux's comments accordingly to the 4-year gap between his phone conversation and the event in question. Furthermore, this implies that the more accurate histories were obtained by the PCP Mia Saenz APRN, cardiologist Dr. Motta, and neurologist Dr. Aguilar when compared to his own.

One of the points Dr. Deveraux uses in suggesting that a seizure was not the etiology of the event was that "80% of second seizures occur within two years of the initial unprovoked seizure." No references are cited. However, the documented rate of second seizure after an unprovoked seizure has been shown to be 29% at 3 years (Hauser et al, Neurology, 1990) and 33% at 5 years (Hauser et al, NEJM, 1998). This means that Mr. Carrillo had between a 29-33% chance of having a subsequent seizure during the time he was under restrictions. Even if we use Dr. Devereaux's estimated percentage, Mr. Carrillo would be predicted to have a 20% chance of having a subsequent seizure during the period of restriction. All of these percentages would have placed Mr. Carrillo at an unacceptably high risk of sudden incapacitation.

It is my opinion based on the available evidence that it is more likely than not (and quite probable) that Mr. Carrillo suffered an unprovoked epileptic seizure. This is supported by the lateral tongue injury, prolonged recovery, and concurrent shaking movements. This is also the conclusion of Drs. Frankel and Holland. The treating neurologist Dr. Aguilar also treated Mr. Carrillo as if he had a single unprovoked seizure. While convulsive syncope or syncope with resultant concussion can not be definitively excluded, there is no objective evidence to support those possibilities, and they are much less likely. It is nearly impossible for anyone at this point to determine if Mr. Carrillo's event of late June 2021 was an unprovoked seizure or syncope. Regardless, in clinical medicine and especially neurology we very often face uncertainty about a diagnosis. The standard practice when faced with two possible diagnoses is to err on the side of caution and respect both diagnostic possibilities but apply restrictions or preventative measures based on the diagnosis that is most serious or likely to cause subsequent harm. In Mr. Carrillo's case that diagnosis is

clearly that of an epileptic seizure. As such, it was very appropriate for Union Pacific Railroad to apply the 5-year restrictions associated with an epileptic seizure.



T. Scott Diesing, M.D., FHM
Neurohospitalist
Medical Director of Inpatient Neurology Services
Division Chief of General Neurology
Associate Professor
Department of Neurological Sciences
University of Nebraska Medical Center
988440 Nebraska Medical Center
Omaha, NE 68198-8440

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402.559.9953 / fax 402.559.3341 / unmc.edu/neurologicalsciences

CURRICULUM VITAE

Exhibit ZZ

T. Scott Diesing, M.D.
Department of Neurological Sciences
University of Nebraska Medical Center
988440 Nebraska Medical Center
Omaha, NE 68198-8440
Office (402) 552-6605
Cell (402) 541-4585
tdiesing@unmc.edu

EDUCATION:

B.A., Biology

August 1993 – May 1995	Northwest Missouri State University Maryville, MO
August 1995 – May 1998	University of Nebraska at Omaha Omaha, NE

M.D.

August 1998 – May 2002	University of Nebraska Medical Center Omaha, NE

POST-DEGREE TRAINING:

Internship

June 2002 – June 2003	Internal Medicine, Mayo Clinic Rochester, MN

Residency

June 2003 – June 2006	Neurology, Mayo Clinic Rochester, MN

ACADEMIC APPOINTMENTS:

July 2020 – Present	Academic Associate Professor Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE
July 2018 - Present	Division Chief – General Neurology & Neurohospitalist Medicine, Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE
October 2018 – Present	Faculty Senate University of Nebraska Medical Center Omaha, NE
2017 – Present	Chair – Quality Safety and Performance Department of Neurological Sciences

	University of Nebraska Medical Center Omaha, NE
June 2016 – October 2018	Faculty Senate Alternate University of Nebraska Medical Center Omaha, NE
November 2014 - Present	Academic Assistant Professor, Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE
November 2014 – Present	Director of Hospital Neurology Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE
July 2006 – November 2014	Adjunct Clinical Professor/Clinician Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE

CERTIFICATIONS AND LICENSES:

2008 – Present	Neurology, American Board of Psychiatry and Neurology
2008 – 2018	EMG, American Board of Electrodiagnostic Medicine
2006 – 2020	Physician Nebraska, 23574 (Active, unrestricted)
2016 – 2019	Physician Iowa, MD-43214 (Active, unrestricted)

OTHER APPOINTMENTS:

July 2020 – Present	Director & Mentor, Clinical Neurology Rotation Physician Assistant Program College of Saint Mary Omaha, NE
March 2020 – Present	Special Appointment, COVID-19 Crisis Czar Department of Neurological Sciences University of Nebraska Medical Center Omaha, NE
November 2019 - May 2020	Chair, Physician Investigations, Medical Staff Nebraska Medicine Omaha, NE
October 2018 – Present	Service Line Chief, Neurosciences Medical Executive Committee Nebraska Medicine Omaha, NE
October 2017 – Present	Chair – Unit Based Medical Directors Nebraska Medicine

	Omaha, NE
July 2015 - Present	Mentor, Quality & Performance Improvement University of Nebraska Medical Center Neurology Residency Program
July 2015 - Present	Telestroke Program Department of Neurological Sciences University of Nebraska Medical Center
November 2014 – Present	Medical Director – Neuroscience Unit Nebraska Medicine Omaha, NE
2013 – 2014	PHO Board Member Methodist / Physicians Clinic Omaha, NE
2012 – Present	Advisory Board Member Live On Nebraska (formerly Nebraska Organ Recovery System)
April 2012- October 2014	Managing partner Neurology, LLP Omaha, NE
2010 - 2014	Medical Director - EMG Clinical Neurophysiology Lab Nebraska Medical Center Omaha, NE
March 2010 – October 2014	Medical Director – Stroke Program Nebraska Methodist Hospital Omaha, NE
2009 - Present	Board member Nebraska Medical Education Foundation
2006 - 2014	Physician Neurology, LLP Omaha, NE

CONSULTING POSITIONS:

December 2017 – Present	Reviewer Journal of Neurological Sciences

HONORS AND AWARDS:

2020	Resident Advocacy & Mentorship Award - University of Nebraska Medical Center Neurology Residency Program

2020	Impact in Education Award, Inspirational Mentor of Educators: Nomination – University of Nebraska Medical Center
2020	Physician Leadership Program, Health Management Academy Washington, D.C.
2019	Impact in Education Award, Inspirational Mentor of Educators: Nomination – University of Nebraska Medical Center
2019	Most Effective Rounding Award - University of Nebraska Medical Center Neurology Residency Program
2018-2019	Teacher of the Year - University of Nebraska Medical Center Neurology Residency Program
2018	Impact in Education Award, Inter-professional Education Scholar: Nomination - University of Nebraska Medical Center
2018	Physician of the Quarter - Q1, Nebraska Medicine Neuroscience Unit Omaha, NE
2017	Quality & Safety Educators Academy – Society of Hospital Medicine Tempe, AZ
2017	Physician Leadership Academy Nebraska Medicine
2016	Most Effective Rounding Award - UNMC and Creighton University Joint Neurology Residency Program Omaha, NE
2015-2016	Teacher of the Year - UNMC and Creighton University Joint Neurology Residency Program Omaha, NE
2015	Physician of the Quarter - Q2, Nebraska Medicine Neuroscience Unit Omaha, NE
2014-2015	Teacher of the Year – UNMC and Creighton University Joint Neurology Residency Program Omaha,
2013	Meaning of Care Award - Nebraska Methodist Health Omaha, NE
2012	Emerging Leader Award - Private Practice Associates
2005	Resident Scholarship - American Academy of Neurology
2001-2002	Scholarship - Nebraska Medical Foundation
2000-2001	Full Tuition Scholarship – University of Nebraska Medical Center
1999	Summer Research Scholarship – University of Nebraska Medical Center
1997-1998	State Scholarship - University of Nebraska Honor Society - Omicron Delta Kappa Honor Society - Golden Key

MEMBERSHIPS AND OFFICES IN PROFESSIONAL SOCIETIES:

Present	Member – Nebraska Neurologic Society
Present	Member - Omaha Medical Society
Present	Member - Neurohospitalist Society
Present	Member - American Medical Association
Present	Member - Nebraska Medical Association
Present	Member - Society of Hospital Medicine
Present	Member - American Academy of Neurology
Present	Member - Mayo Clinic Alumni Association
2014 - 2018	Member - Neurocritical Care Society

2008 - 2018	Member - American Association of Neuromuscular & Electrodiagnostic Medicine
1998 - 1999	Student Elected Representative - Student Ethics Committee, University of Nebraska Medical Center

COMMITTEE ASSIGNMENTS:

November 2019 - Present	Physician Investigations, Medical Executive Committee Nebraska Medicine
July 2019 – Present	Core Event Review Team Committee Nebraska Medicine
January 2019 – 2020	Vizient Hospital Design Committee Nebraska Medicine
October 2018 – Present	Chief, Neurosciences Service Line Medical Executive Committee Nebraska Medicine
July 2018 – Present	Clinical Operations Committee (formerly Senior Leadership Committee) Department of Neurological Sciences University of Nebraska Medical Center
July 2018 - Present	Capacity & Throughput Committee Nebraska Medicine
October 2017 – Present	Chair – Unit Based Medical Directors Leadership Committee Nebraska Medicine
July 2017 – Present	Chair – Quality Safety and Performance Department of Neurological Sciences University of Nebraska Medical Center
July 2016 - Present	Utilization Management Committee Nebraska Medicine
July 2016 - Present	Pharmacy & Therapeutics Committee Nebraska Medicine
July 2016 - Present	Core Curriculum Committee University of Nebraska Medical Center Neurology Residency Program
July 2016 - Present	Mortality Committee Nebraska Medicine
July 2016 - Present	Quality & Safety Committee Nebraska Medicine
July 2015 - Present	Clinical Learning Environment Review Committee University of Nebraska Medical Center Neurology Residency Program

July 2015 - Present	Comprehensive Stroke Center Steering Committee Nebraska Medicine
July 2015 - Present	Patient & Provider Experience Committee Nebraska Medicine
July 2015 - 2019	One Chart Patient Steering Committee Nebraska Medicine
July 2015 - Present	EPIC One Chart Physicians Advisory Committee Nebraska Medicine

INVITED EXTRAMURAL PRESENTATIONS:

1. Diesing TS. Neurologic Aspects of COVID-19. 2020 May. Learning As We Go Webinar
2. Diesing TS. COVID-19 Related Changes in Acute Stroke Management. 2020 May. Nebraska Telestroke Network
3. Diesing TS. Delirium. 2020 July. College of St. Mary Physician Assistant Program
4. Diesing TS. Neuroinfectious Diseases. 2020 July. College of St. Mary Physician Assistant Program
5. Diesing TS. Neurology in the Hospital. 2017 Apr. Omaha Public Schools
6. Diesing TS. What is a Neurohospitalist? 2016 Nov. Creighton University Medical School
7. Diesing TS. Practical Stroke and Seizure Update. Department of Nursing; 2014 Sept. Nebraska Methodist Hospital
8. Diesing TS. Progressive Supranuclear Palsy. Hillcrest Annual Rehab Health Services; 2013 Apr
9. Diesing TS. Visual Deficits and Stroke. 10th Annual Nebraska Stroke Symposium; 2011
10. Diesing TS. Neuroanatomy. Annual Rehab Conference; 2010. Nebraska Methodist Hospital, Omaha, NE
11. Diesing TS. Critical Care Nursing. Educational Conference; 2010. Nebraska Methodist Hospital, Omaha, NE
12. Diesing TS. Parkinson's disease. Nebraska Academy of Family Physicians Fall Conference. 2010
13. Diesing TS. Prion Disease. Critical Care Conference; 2008 Nov. Nebraska Methodist Hospital, Omaha, NE
14. Diesing TS. Multiple Sclerosis. Critical Care Conference; 2007 Jun. Nebraska Methodist Hospital, Omaha, NE
15. Diesing TS. Annual Nursing Education Conference. 2007. Alegent Health System, Omaha, NE
16. Diesing TS. Amyotrophic Lateral Sclerosis. Critical Care Conference; 2006 Aug. Nebraska Methodist Hospital, Omaha, NE

COMMUNITY SERVICE/OUTREACH:

2017 – Present	High School Alliance Project, Mentoring high school students in health careers Omaha Public Schools
2017	Concussion Awareness & Education Omaha Catholic Schools
1998 - 2000	Spanish Translator – SHARING Clinic (a student operated health clinic for the medically underserved) Omaha, NE

TEACHING ACTIVITIES:

2020 – Present	Clinical Neurology for Psychiatrists, Board Review Psychiatry Residency Program University of Nebraska Medical Center
2018 – Present	Medical Student Neurology Core Lecture Series College of Medicine University of Nebraska Medical Center
2018 – Present	Emergency Medicine Neurology Lecture Series Emergency Medicine Residency University of Nebraska Medical Center
April 2018	Neuroscience Symposium: Stroke Prevention Nebraska Medicine
2017 – Present	Founder, Curriculum Creator, Director, & Lecturer Quality Improvement & Patient Safety Curriculum Neurology Residency University of Nebraska Medical Center
2017 – Present	Continuing Education Lectures Department of Nursing Nebraska Medicine
2015 – Present	Neurology Emergency Lecture Series Neurology Residency University of Nebraska Medical Center
2015 – Present	Annual Neurosciences Grand Rounds Department of Neurological Sciences University of Nebraska Medical Center
2015 – Present	Neurology Core Didactic Lecture Series Neurology Residency University of Nebraska Medical Center

PUBLICATIONS:

Articles published in scholarly journals

1. Diesing TS, Swindells S, Gelbard H, Gendelman HE. HIV-1-associated dementia: a basic science and clinical perspective. AIDS Reader. 12: 358-68. 2002
2. Diesing TS, Wijdicks EF. Ping-pong gaze in coma may not indicate persistent hemispheric damage. Neurology. 63: 1537-8. 2004
3. Diesing TS, Wijdicks EF. Arc de cercle and dysautonomia from anoxic injury. Mov. Disord. 21: 868-9. 2006
4. Warchol JM; Cooper JS; Diesing TS. Hyperbaric oxygen-associated seizure leading to stroke. Diving Hyperb Med. 2017 Dec; Vol. 47 (4): p. 260-262
5. Villafuerte Trisolini BJ, Taha M, Yousif Matloub MS, Diesing TS. A case of monocytic pleocytosis in West Nile Virus encephalitis and review of the literature. Ann Indian Acad Neurol. 2020 Sep-

Oct;23(5): 687-688.

Chapters in books

1. Gendelman HE, Diesing S, Gelbard H, Swindels S. The Neuropathogensis of HIV-1 Infections. In: Wormser G, ed.AIDS and Other Manifestations of HIV Infection. 4th ed. Academic Press, 2004.
2. Diesing TS, Rizzo M. Medical Assessment of the Aging Mind and Brain. In: Rizzo M, ed The Wiley Handbook on the Aging Mind and Brain. 1st ed. John Wiley & Sons Ltd, 2018.

Abstracts and preliminary communications

1. Stenzel L, Diesing TS, Kaluza J. Standardization and facilitation of clinical documentation for acute stroke improves adherence to stroke core measures. University of Nebraska Department of Neurological Sciences Research Conference. 5/2016: Omaha, NE.
2. Galla K, Diesing TS, et al. Factors affecting post-discharge outcomes in hospital patients with non-surgical neurological diseases. Platform poster presentation 69th Annual American Academy of Neurology Conference. 4/2017: Boston, MA.
3. Balasetti V, Galla K, et al. Post hospitalization follow-up clinic visits in neurologic diseases. Poster presentation 69th Annual American Academy of Neurology Conference. 4/2017: Boston, MA.
4. Ahmed F, Balasetti v, et al. Factors in Unplanned Readmission or ED visit within 30 days of discharge from an inpatient neurology service. Platform poster presentation 69th Annual American Academy of Neurology Conference. 4/2017: Boston, MA.
5. Baang H, Sajja K, Arcot L, Diesing TS, Murman D. The influence of delirium on theprognosis of acute stroke. University of Nebraska Department of Neurological Sciences Research Conference. 5,2017: Omaha, NE.
6. Baang H, Diesing TS, Gonzalez M. Diffuse ischemic brain injury with moderate grade carotid stenosis. University of Nebraska Department of Neurological Sciences Research Conference. 5,2017: Omaha, NE.
7. Baang H, Diesing TS. Catastrophic reversible cerebral vasoconstriction syndrome with bilateral intraocular hemorrhage. 70th Annual American Academy of Neurology Conference. 4/2018: Los Angeles, CA.
8. Baang H, Diesing TS, Murman D. Delirium Assessment for acute ischemic stroke patientsat UNMC. University of Nebraska Medical Center Graduate Education Research Meeting. 10/2018: Omaha, NE
9. Baang H, Diesing TS, Murman D. Delirium Assessment for acute ischemic stroke patients at UNMC. 71st Annual American Academy of Neurology Conference. 4/2019: Philadelphia, PA.
10. Smith E, Diesing TS. Strategies to decrease post hospital discharge negative outcomes for patients with neurological diseases. 71st Annual AmericanAcademy of Neurology Conference. 4/2019: Philadelphia, PA.
11. Purbaugh M, Diesing TS. Neuroinvasive West Nile virus: A case series in Nebraska. 71st Annual American Academy of Neurology Conference. 4/2019: Philadelphia, PA.

Exhibit AAA

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF TEXAS

EL PASO DIVISION

* * *

JOSEPH CARRILLO,

Plaintiff,

vs. CASE NO. 3:21-cv-00026-FM

UNION PACIFIC RAILROAD CO.,

Defendant.

* * *

Deposition of MICHAEL DEVEREAUX, M.D., Witness herein, called by the Defendant for cross-examination pursuant to the Rules of Civil Procedure, taken before me, Mindy R. Huffman, a Notary Public in and for the State of Ohio, with the Witness appearing in Cleveland, Ohio, on Tuesday, February 22, 2022, at 1:01 p.m.

* * *

APPEARANCES:
On behalf of the Plaintiff:

Nichols Kaster, P.L.L.P.

By: Lucas J. Kaster
Attorney at Law
4700 IDS Center
Minneapolis, Minnesota 55402
612-256-3231
lkaster@nka.com

On behalf of the Defendant:

Constangy, Brooks, Smith & Prophete, L.L.P.

By: Robert L. Ortbals, Jr.
Attorney at Law
680 Craig Road, Suite 400
St. Louis, Missouri 63141
314-338-3740
rortbals@constangy.com

ALSO PRESENT:
Joseph VanDetta, videographer

* * *

THE VIDEOGRAPHER: We are now on the record. The date is Tuesday, February 22nd, 2022. The time is 1:01 p.m. The caption of the case is Joseph Carrillo vs. Union Pacific Railroad Company. The name of the witness is Dr. Michael Devereaux.

At this time, the attorneys present will identify themselves for the record.

MR. ORTBALS: Bob Ortbals for Defendant, Union Pacific.

MR. KASTER: Lucas Kaster on behalf of the plaintiff.

THE VIDEOGRAPHER: Thank you.

Will the court reporter please swear in the witness?

MICHAEL DEVEREAUX, M.D.
of lawful age, Witness herein, having been first duly cautioned and sworn, as hereinafter certified, was examined and said as follows:

CROSS-EXAMINATION
BY MR. ORTBALS:

Q. Can you state your name for the record, please?

A. Michael Devereaux.

Q. And you're a medical doctor; is

that correct?

A. Correct.

Q. And, Dr. Devereaux, I deposed you yesterday in another matter, and I know you've been deposed numerous times in the past, so I'm not going to go through all the deposition rules and guidelines here up front.

Just as I did yesterday, I'll remind you, if at any point you don't hear a question clearly, since we're doing this remotely, over Zoom, if there's an issue with the video or audio feed or anything like that or you need me to re-ask a question or you don't quite understand a question I'm asking you, just absolutely let me know and I'll rephrase or re-ask the question as needed.

I don't think we're going to go as long as we did yesterday, but if at any point in time you need to take a break, just let us know and we'll be happy to take a break. Okay?

A. Yes, sir. Thank you.

Q. All right.

(Thereupon, Exhibit 72, curriculum vitae, was marked for purposes of identification.)

BY MR. ORTBALS:
Q. And I've just shared what has been marked as Exhibit 72. Doctor, this is an updated version of your CV that you sent about a month ago; is that correct?
A. Yes, sir. Excuse me. Yes, sir.
Q. And there's nothing that needs to be added to this CV to make it current; is that right?
A. No, sir.
Q. And turning to the second page of Exhibit 72, it looks like you've been board certified since the mid 1970s by the American Board of Psychiatry and Neurology and the American Board of Clinical Neurophysiology; is that right?
A. Yes, sir.
Q. And both of those certifications are still current?
A. Yes, sir.
Q. And then going to page 3 of the exhibit, it looks like you have served as the professor of neurology at Case Western Reserve University since 1996; is that right?
A. Yes, sir.

Q. And you're still in that position today?
A. Yes.
Q. And do you maintain a clinical practice outside of your academic role?
A. I'm not sure how to answer that because my clinical work is part of my academic role. I'm salaried through University Hospital as part of the Case Western Reserve University system, so I'm not in private practice.
Q. Why don't you just briefly describe your responsibilities as professor of neurology.
A. Well, they cover various issues based on my activities. I teach on the inpatient clinical neurology service. I run the residents continuity clinic. I teach and read EEGs with the epilepsy fellows as part of their fellowship training. I see patients now mostly through the residents clinic and when I'm on the inpatient services. And, of course, as anybody who is in an academic setting, a large amount of my time is also spent teaching in various venues, including lectures at the medical school, teaching medical students, the

inpatient and outpatient services, running an EEG epilepsy course. I teach a course on -- we have an eight-week course we offer here. Is that good enough?
Q. Absolutely. Thank you, Doctor. All right. Doctor, I've just -- I'm going to do it this way. I'm going to pull this exhibit up separately.
(Thereupon, Exhibit 73, testimony history, was marked for purposes of identification.)
BY MR. ORTBALS:
Q. All right. Doctor, I've just shared on the screen what has been marked as Exhibit 73, and this is the testimony history you produced with your expert report; is that correct?
A. Yes, sir.
Q. And it looks like, in April of 2018, you gave testimony in a case John Baker, Quinton Harris, Thomas Taylor vs. Union Pacific; is that right?
A. Yes, sir.
Q. And you were retained by Nichols Kaster to participate in that case; is that

correct?
A. Yes, sir.
Q. And that's the same firm representing Mr. Carrillo in this case; is that right?
A. Yes, sir.
Q. And the opposing party in the Baker case was Union Pacific; is that right?
A. Yes, sir.
Q. And then on March the 2nd, 2020, you gave testimony in a case Mark Hayhurst vs. Union Pacific; is that right?
A. Yes, sir.
Q. And Mr. Hayhurst was represented by Nichols Kaster, who retained you to give an opinion in that case?
A. Correct.
Q. And then yesterday you testified in the case John Ingram vs. Union Pacific; is that right?
A. Correct.
Q. And Nichols Kaster represented Mr. Ingram, right?
A. Correct.
Q. And they are the ones who retained

you to provide an opinion in that case?
A. Correct.
Q. I think yesterday you mentioned there was a case starting with a B against Union Pacific that you thought you might be giving testimony in. Have you figured out what the name of that case is?
A. Is that listed here under 9/10? I didn't look it up, but -- it is a case through the same Kaster law firm that involves Union Pacific, but I did not look it up. As I understand it, we're working towards establishing a deposition time for that case sometime in the next month or two.
Q. Are there any other cases where you've been retained by Nichols Kaster to provide an opinion on behalf of one of its clients?
A. I don't believe so.
THE WITNESS: Mr. Kaster, are you aware of anything else? I don't believe so.
BY MR. ORTBALS:
Q. Are there any other cases in which you've been retained as an expert in which Union Pacific was an opposing party?

A. Are there any other cases, you're saying -- asking other than Union Pacific, as in a person?
Q. No. I'll ask it -- are there any other cases where you've served as an expert witness involving Union Pacific that we haven't already talked about?
A. I don't believe so.
(Thereupon, Exhibit 74, report, was marked for purposes of identification.)
BY MR. ORTBALS:
Q. All right. Doctor, I've just shared on my screen what's been marked as Deposition Exhibit 74.
MR. ORTBALS: And, Lucas, so you know, I'm also simultaneously introducing these through Exhibit Share so -- it's easier for me to share the screen this way than through Exhibit Share, so --
MR. KASTER: Thanks.
MR. ORTBALS: Absolutely.
BY MR. ORTBALS:
Q. And this is a copy, Doctor, of your October 21st, 2021, report that you prepared for this case; is that correct?

A. Yes, sir.
Q. And if we look kind of toward the bottom -- well, I guess technically it's the middle, but the bottom of what's on the screen of the first page of the exhibit, you're being paid for your time to provide an opinion in this case; is that right?
A. Yes, sir. As I've said before, my thanks to you for the residents of University Hospital since all that money is going into an endowment fund for resident education. So they send their thanks to you, sir.
Q. Our pleasure.
A. Yeah, I'm sure.
Q. In preparing your report, you did not examine Mr. Carrillo; is that correct?
A. That is correct. I did speak to him, as you know, but I did not examine him.
Q. And then at the top of your report, kind of the first paragraph of your report lays out various documents that you reviewed in preparing your report; is that correct?
A. Yes, sir.
Q. And are there any additional

documents that you reviewed in preparing your report that aren't referenced?
A. I don't believe so, no, just, you know, the 647 pages, one aliquot and the 29 pages of another are my source outside of my conversations with the patient and his significant other.
Q. And your opinions in Exhibit 74, are any of them based on any information other than the documents listed or other references contained in your report?
A. No, except, as I say, to the -- the added conversations with -- with Mr. Carrillo and his significant other, which I consider to be fundamentally important.
(Thereupon, Exhibit 8 from a prior deposition, Saenz report, was presented for purposes of identification.)
BY MR. ORTBALS:
Q. Okay. Doctor, I've just shared what's been marked -- previously marked as Exhibit 8. Are you able to see that on your screen?
A. Yes, I do.
Q. Okay. And Exhibit 8 is a

June 30th, 2017, medical note from provider Mia Saenz; is that correct?
A. Yes.
Q. And this is one of the medical records you reviewed in preparing your report; is that correct?
A. Yes.
Q. And this was the medical examination conducted by Mr. Carrillo's primary care provider within days of his loss of consciousness; is that right?
A. Yes, a clinical nurse practitioner.
Q. And you're aware, Doctor, in some jurisdictions nurse practitioners are able to serve as a patient's primary care?
A. Yes. I consider that a mistake, by the way.
Q. And toward the mid bottom of the first page of Exhibit 8, Bates numbered 000325, you see there's a history of present illness section?
A. Yes, sir.
Q. And in that section, Dr. Saenz -- I realize is not a medical doctor, but she's

actually a Ph.D. -- records notes that Mr. Carrillo reported that he was taking a shower, and while getting ready for work, fainted and just remembers waking up on the floor; is that correct?
A. Yes.
Q. And then she notes --
A. That is not correct, but it is correct as far as what is written there.
Q. It's what Dr. Saenz reported within days of Mr. Carrillo's loss of consciousness; is that right?
A. Well, not Dr. Saenz. Nurse Practitioner Saenz. Yes.
Q. Okay. She's a Ph.D., Doctor?
A. I don't care. She's listed as a clinical nurse practitioner or advanced nurse practitioner, not a Ph.D. in all the stuff I reviewed.
Q. All right. And then Dr. Saenz notes that Mr. Carrillo's wife then came into the room and found him lying on the floor; is that correct?
A. That's what she wrote.
Q. And she noted that Mr. Carrillo

denied having any symptoms before fainting; is that right?
A. That's what she wrote. And, Ken, it depends on what you mean by symptoms because he had been sick for four days before, as others have noted.
Q. Well, this is two days after his loss of consciousness; is that right?
A. Yes.
Q. Okay. And there's no report of dizziness made; is that correct?
A. No report of -- say that again.
Q. There's no report of dizziness?
A. No.
Q. There's no report of nausea?
A. No.
Q. There are no flu-like symptoms reported?
A. No. That was all missed.
Q. There's no diarrhea reported?
A. No. That was also missed.
Q. Well, you're assuming that based on what Mr. Carrillo has told you four years later, Doctor?
MR. KASTER: I'm objecting to --

THE WITNESS: No, no, no.
MR. KASTER: Hold on. Hold on, Doctor. Hold on, Doctor. I'm objecting to form and foundation. It mischaracterizes the evidence. Go ahead.
THE WITNESS: The physicians who -- and the railroad people all note that he had been sick for four days before and two days after. That's in reports of the physicians that you consulted for expert advice. Unfortunately that was not listed, but others have noted it as well, not just me. That comes in information in the medical records, not just in the conversation that I had with both Mr. Carrillo and now his wife, Mrs. Carrillo.
BY MR. ORTBALS:
Q. There's no feelings of dehydration reported; is that correct?
A. There's --
MR. KASTER: Same -- hold on. Same objections. You can answer, Doctor.
THE WITNESS: No, there's -- none of that is listed, which others have listed.
BY MR. ORTBALS:
Q. Then if we go to the second page

of the document, UPCARRILLO326, there's a review of systems section. Do you see that, Doctor?
A. Right.
Q. And in the systemic section, Dr. Saenz records that Mr. Carrillo was not feeling poorly, no fever, no chills and no recurrent weight change; is that right?
A. Yes. It was also missed, as it has not been missed by other physicians involved, including Dr. Aguilar, who saw him as a neurologist.
Q. There's no report of flu-like symptoms there; is that right?
A. Correct.
Q. And then in the gastrointestinal system review, it's noted that Mr. Carrillo had normal appetite, no dysphasia -- which is difficulty swallowing -- no heartburn, no nausea, no vomiting, no abdominal pain and no diarrhea; is that right?
A. This is boilerplate. She pushed a button, and all this came out.
Q. Have you talked to Dr. Saenz to determine what she did to examine Mr. Carrillo?

foundation. You can answer if you can, Doctor.
THE WITNESS: I'm sorry. My computer just shut down, and I just came back online. Would you just repeat the question for me?
BY MR. ORTBALS:
Q. Sure.
A. I heard the objection, but --
Q. Dr. Aguilar's records indicating that Mr. Carrillo was suffering from flu-like symptoms are the first records -- medical records in this case that have such a report in them; is that right?
A. Right.
Q. If we go to page 3, Bates number UPCARRILLO327, on to page 4, 328, there's a physical findings section prepared by Dr. Saenz, and you would agree with me that there's nothing in those physical findings demonstrating Mr. Carrillo was suffering from the flu or flu-like symptoms?
A. Well, there wouldn't be any at this point.
Q. What makes you say that?
A. Well, the vast majority of patients, even in the midst of a flu, if you

A. No.
Q. So you don't know what her methodology was at all.
A. Yes, I do. I've seen it over and over and over and over again. It's one of the problems with the computerized system. All this is preprint. You just push a button. And you, as lawyers, know that that's how it works. I know how it works as well. That's what's here.
As I've already stated, other physicians involved in this case have noted his symptoms before or after, including Dr. Aguilar, who saw him as a neurologist, who he was referred to by this practitioner.
Q. Doctor, you have no personal knowledge of what Dr. Saenz did in preparing this medical report; is that right?
A. No, of course not.
Q. And Dr. Aguilar's records related to Mr. Carrillo's flu-like symptoms are the first time that any type of flu-like symptoms are mentioned in the medical records; is that right?
MR. KASTER: Objection to form and

see anything, there will be fever. And this is two days after his event, as noted, and his symptoms, as he has stated and as others have stated, resolved after two days.
Q. All right. Doctor, I've brought back up Exhibit 74, your report, and toward the bottom of the first page, you write: It should be noted that Dr. Aguilar saw Mr. Carrillo five to six weeks after the event. Do you see that?
A. Yes, I do.
Q. Why did you note that?
A. Because it was in the record, and I noted the date because that was the date he saw the patient.
Q. Right, but you could have just noted the date of the record. Why did you specifically call out in your report that this date is five to six weeks after Mr. Carrillo's loss of consciousness?
A. There's nothing that I can recall in making the report other than to note that it was five to six weeks removed from the event in question, but there's nothing -- I can't offer you anything more than that response.
I mean, you're obviously placing a

lot of importance to the initial evaluation two days later and this evaluation six weeks later.
Q. Well, let me ask you this, Doctor: In your experience as a physician, does the passage of time reduce the reliability of a patient's memory in reporting their symptoms?
A. Well, yes, but then there are other issues here, aren't there? And that is that Mr. Carrillo, as has been noted by all except the initial evaluation, had some post-event symptoms, including changes in memory. And how much that played a role, I can't tell you for sure, but it's not at all -- it's hard for me to know exactly the tack you're taking. Are you suggesting that when he got to Dr. Aguilar, he made all this symptomology up, or is it just that the way neurologists work versus the way primary care physicians work who see 20 to 30 patients a day and take much more scant constant histories. Neurologists spend usually an hour with a patient -- a new patient evaluation. We obviously pick up more information.
Q. I didn't take any tack. I just asked if you, as a physician, feel that memory

is less reliable the longer in time that has passed?
A. Well, he seems to remember more when he got to see Dr. Aguilar than he did when he saw the physician initially -- the nurse practitioner initially.
Q. And then turning to the second page of Exhibit 4, you note that Dr. Aguilar offered a differential diagnosis for the loss of consciousness episode that included a single unprovoked seizure and syncope; is that right?
A. And also a number of other conditions or several other conditions, I should say.
Q. Sure. And I'll ask you about those in just a minute, but you would agree -- you don't disagree that unprovoked seizure and syncope were potential diagnoses for Mr. Carrillo; is that right?
A. Yes, given the mistake that was made, and the mistake that was made which runs through this entire report and this entire issue is they didn't take a history -- they didn't take an adequate history.
It's fundamental in neurology that

when you have an observed spell, you talk to the observer, and no one talked to the observer, because the patient can't fully know what happened to him, in particular if, as I suspect, he had a concussion secondary to the fall, secondary to his sudden loss of consciousness. That's the situation that we are faced with, and that's why I essentially wrote two reports here, the first that you're reading from, which was prepared on October the 13th, and the second report and one in the form of addendums which was completed after I spoke to Mrs. Carrillo -- now Mrs. Carrillo and the patient, Mr. Carrillo. No one talked to either one, most important to her, and that's -- so we can go on and go and on because we're all churning the same information, and that is based on what the patient could tell, even though he was the one that was unconscious. That's not fancy professorial neurology. That's fundamental resident neurology. You talk to the observer, and no one did that. And as a result, they didn't get a complete history.
Q. Well, Doctor, first of all, your report is dated October 21st; is that correct?
A. Yes.

Q. It's not dated October 13th.
A. I just -- I dictated the first part October 13th. Then when I talked to Mr. Kaster and asked if I could speak to the patient -- really to the observer, I did that on October 21st. And so rather than -- basically you could look at this as two reports, the information that everybody else had after the primary evaluations and then the information that I added, because I did what a good resident would do, and that is I talked to the observer of the spell and I put it all together in one report.
Q. Well, Doctor, when you speak about the observer of the spell, you're talking about Mrs. Carrillo; is that right?
A. Yes.
Q. You're not talking about the patient, Mr. Carrillo.
A. No. He doesn't know anything. He hit the deck. He just lost consciousness running to the bathroom, and like most individuals who had an unobserved spell, he can't tell you very much.
Q. Four years later, he can't tell

you very much.
A. Say that again.
Q. Four years later, he can't tell you very much.
A. He can tell you more than the observers to that point, the physicians who never talked to him. I'm sorry that it was a four-year delay. It's because no one talked to him sooner.
Q. So wait. It's your position that none of the physicians who treated Mr. Carrillo and created medical records of their examinations of him talked to him during their examination.
A. No.
Q. Is that what your testimony is?
A. Let me rephrase it to make it clear. The mistake that was made was not talking to now Mrs. Carrillo, who observed the spell as outlined in my addendum based on a conversation I had with her. That was the error.
As I tell you, when you come to a spell like this where there is an observer who doesn't show up, what is the most important

technology you can apply to the situation? That's a cell phone because everybody has a phone now. And the thing that you do and the thing I teach my residents to do is if someone comes in having had an episode of altered awareness and there was an observer, you call the observer. That's resident medicine. You talk to the observer. Anything you want to read about episodes and taking a history like this is if there's an observer, you talk to the observer.
Q. Except, Doctor, what Mr. Carrillo reported to Dr. Saenz is that he passed out after taking a shower.
A. He didn't.
Q. But he -- but, Doctor, that's your -- that's your opinion based on --
A. That's not my opinion. It's not my opinion. It's the opinion of an observer who watched him go down. He was confused afterward. He has a memory impairment. He probably had a concussion. Individuals who have an episode like this often have retrograde amnesia for the episode, and the observer becomes fundamental. That was the mistake that was made. No one had talked to the observer

before I did.
Q. So, Doctor, it's your testimony that Mr. Carrillo couldn't have possibly remembered whether he had taken a shower when he reported that --
A. Yes, yes. There are several observers -- we know that -- that give different stories, one that he was on the way to the bathroom and the other one, that he was in the shower. The man was confused afterwards.
Q. And so when Dr. Aguilar notes that Mr. Carrillo told him that he recalled brushing his teeth in the bathroom, your position is that Mr. Carrillo could have had no idea what he was talking about?
A. He may have -- he may have actually had not only retrograde amnesia. He may have been had post-event amnesia, particularly if he had a concussion.
The fact of the matter remains. When you challenge me about that, what you really have to do is challenge the observer. And the way I took a history is -- I think Mr. Carrillo will support -- I made it very clear I didn't want any

information other than what the patient could remember, and I didn't ask any leading questions. I just asked her, tell me what you saw, and I recorded what she saw.
And I don't think anybody is making that up. They don't even know to make that up. So there is -- and we can sit here until tomorrow morning talking about this, but the issue is what she saw and no one interviewed her.
In fact, the primary care physician or, in this case, nurse practitioner should have done that two days later, and then we wouldn't be having this meeting.
Q. Doctor, you interviewed Mrs. Carrillo on October 21st, 2021; is that right?
A. Yes, sir.
Q. You would agree with me that was over four years after Mr. Carrillo's loss of consciousness?
A. Unfortunately so, because no one else did it.
Q. And you spoke with her over the telephone?
A. That is correct.

Q. How long of a telephone call was that?
A. I would suspect -- again, Mr. Kaster can correct me if he -- feel free to do so -- but probably about 20 minutes, maybe a bit more because I talked to three people that morning in a row, Mr. Kaster and then now Mrs. Carrillo and then Mr. Carrillo, and I totaled that up as an hour.
Q. Did you talk with each of these three individuals separately or all at the same time?
A. Separately.
Q. So if I understand the sequence, you spoke with Mr. Kaster by phone for --
A. I needed a phone number, and being that this is a legal situation, I thought it appropriate to clear that with Mr. -- his attorney, which I did. And he gave me the phone number, and I called and spoke --
THE WITNESS: What I can't remember, Mr. Kaster, is if you listened into the conversation. I can't remember that.
BY MR. ORTBALS:
Q. Did you take any notes of the

conversation?
A. Well, as I discussed with you yesterday in another case, I wrote down notes as I talked and then immediately created the addendum.
Q. And so you spoke with Mrs. Carrillo after her husband had a lawsuit pending against Union Pacific; is that right?
A. Well, that's right, but that's of no -- that's of no importance to me whatsoever. What I'm doing is carrying out what you do in this case as an expert witness, and that is make a history, create any -- what is my opinion and send it to the attorney with really no concern of whether the attorney likes it or not. But it was just automatic. Someone had to talk to the observer.
Q. And then after you spoke with Mrs. Carrillo, you separately called Mr. Carrillo; is that correct?
A. That is correct. They were not together. He was at work, I suppose, as I think she was.
Q. And did you, similarly, take notes and then transcribe them?

A. Yeah. Actually in those -- in this case since, as I remember correctly, the due date for the report was the 21st, I actually typed my own notes, keyboarded my own notes. I didn't -- I didn't dictate a report and then --
Q. Is what's in the addendum on page 5 onto page 6 then just your typed-up notes?
A. Uh-huh. And by the way, there is a manifestation of my typing. There is a typo in the last paragraph where I write this helps me classify the type of movements that -- it's moments, M O M E N T S. It should read movements. It's several sentences from the end of the report.
Q. Now, Doctor, in your regular practice as a neurologist, how often do you gather patient histories of a loss of consciousness event four years after the fact?
A. If the case comes to me four years after the fact, then I would call the observer.
Q. How many loss of consciousness cases have you dealt with four years after the fact professionally?

A. You know, I can't answer that in all the years I've practiced. It certainly comes up. Most of the time, you're not seeing a patient four years after an event for that event. You're seeing a patient for other events, and you may end up calling to find out about a prior history of events if any of them have been observed.
Q. All right. You would agree with me that gathering a patient's prior history is different than the information that you would ask them to determine their current medical condition and history; is that right?
A. I'm not sure I understand that. Say that again.
Q. Well, let me ask it this way: You mentioned that if somebody does have a past loss of consciousness and they are coming to you years later, it's usually about some type of current medical issue; is that correct?
A. Yes. I mean, most patients don't come to me for a new patient evaluation for an episode that happened four years before. I can't say that's never happened, but it's certainly not routine.

Q. And in terms of gathering the information for their current medical condition, their symptoms, their physical exam, whatever neurological exam you might perform, that's different than the information that you obtain for purposes of determining whether they had a past history of loss of consciousness?
MR. KASTER: I'm going to object to form. You can answer if you can.
THE WITNESS: I'm not sure I can. If a person comes in to me with a current episode of altered awareness or something of a spell, then I would do the same thing. I would gather a history about prior spells. I've certainly seen situations where I've had a person come in with a spell that's been observed where past spells have been observed, and so I will call to find out what the past spells were. I will call the observer if they don't come with the patient as part of completing the history. I'm not sure that answers your question, but that's --
BY MR. ORTBALS:
Q. Will you gather and review their past medical records related to the issue?
A. Would I gather records?

Q. Right.
A. Sure, if they are available. The thing you have to understand, Mr. Ortbals, as I teach and as is certainly the case, neurologists are trained to do histories and physicals. That's what we do. Probably more than any other subspecialty in medicine, history is -- and the literature demonstrates that most diagnoses we make are made by the end of the history. And therefore, anything you can do to obtain history is critical and important, and that -- it depends on the circumstances, but it may mean exploring records from 20 years ago. It may mean -- if they are available. It may mean contacting other institutions for records. All that becomes critical.
Q. Okay. So, Doctor, this whole line of questioning started because I asked you about the differential diagnoses, including single unprovoked seizure, and I want to make sure that I understand your now testimony is that, based on your discussion four years later with Mrs. Carrillo as the observer, you're conclusively opining that Mr. Carrillo did not

suffer from a single unprovoked seizure; is that correct?
A. Correct.
Q. There's no chance he had a seizure?
A. Well, I hate those kinds of statements. We deal in realities, not in absolutes. What I'm telling you is based on the information available from the complete history, everything points to -- away from a seizure and towards a syncopal event, and the critical observer history is what is leading me to that.
If you read the first part of my report before the addendum, it's not that much different from all the other physicians who saw this patient rechurning the same information. I was a little more interested in syncope, along with the cardiologist, as a diagnosis than maybe some of the others, but I was dealing with the same information. What changed my opinion was gathering more history. That's why there's two parts to my report.
Q. So, Doctor, is it your testimony then that the opinions expressed in your

report, the report you produced in this case as your expert opinion, are no longer valid based on a 20-minute telephone conversation four years later with the plaintiff's wife?
MR. KASTER: Objection. Form. Misstates his testimony. You can answer if you can.
THE WITNESS: Correct, because it's a 20-minute conversation no one else had.
BY MR. ORTBALS:
Q. Okay. Doctor, you also mentioned the other -- some of these several other potential differential diagnoses that Dr. Aguilar noted -- TIA, stroke, infection, metabolic encephalopathy -- and you noted that all of which you thought were highly unlikely; is that right?
A. Yes, and I agree with him.
Q. But what was your basis for believing those were highly unlikely diagnoses?
A. Well, there was no evidence to support any of them. TIAs, by their very definitions, are vascular events that usually last minutes without any persistent symptomatology. There's no evidence of a

stroke. He had MRIs that didn't reveal any evidence of a stroke. There's no evidence that he had an infection. He was not treated for an infection, meningitis, whatever. Metabolic encephalopathy, he did have a few laboratory studies that were reported as being mildly abnormal, but nothing that would suggest a metabolic encephalopathy. For sure it was not diagnosed by anybody else. I think those are highly unlikely. Certainly metabolic encephalopathy wouldn't produce the event that he had unless there were other symptoms and other -- i.e., if he had nausea, vomiting, what have you, along with a metabolic encephalopathy, he might have fainted associated with that, but there's really no evidence to any of those conditions.

As my colleagues in Texas would say, this old boy upped and had a spell.

Q. And then if we go to page 3 of your report, you note that Mr. Carrillo had blood tests following his loss of consciousness.

A. Uh-huh.

Q. Some of which revealed

abnormalities, but none of which had any bearing on the loss of consciousness; is that right?

A. Now, that's an interesting question. The -- you're looking at a slightly elevated liver enzyme. What the problem is, these were done a long time later. If he had some significant viral illness, there may have been, you know, other symptoms along with his episode of lost consciousness, but -- how do you answer this -- none of this really pertains to the nature of the spell. I think the nature of the spell is really outlined by Mrs. Carrillo. There could be other -- you know, he was sick.

Q. Let me make sure that I understand your opinion on his syncope now. Are you -- is it your testimony that after speaking with Mrs. Carrillo, you're no longer suggesting that Mr. Carrillo's flu-like symptoms caused his syncope?

A. Oh, I think they probably did.

Q. Okay.

A. I think I made that -- I indicated that -- I beg your pardon. I think I indicated

that in my report, that I think this man, he was sick, nausea, diarrhea, probably hypovolemic. He jumps out of bed suddenly in the morning. Probably everybody involved in this conversation has had an episode where you jump out of bed early in the morning and you get lightheaded, but usually transiently. You wait a minute, and you're fine. Then this man runs to the bathroom and, boom, he goes down. That's a pretty classic story.

Q. Okay. So then what aspect of his illness contributed to the loss of consciousness?

A. Probably volume depletion. That's a history for an event that's generated by orthostatic hypotension.

Q. And when you say orthostatic hypotension, that's the rapid drop of blood pressure to the brain?

A. Yes, and reduced nutrient supply to the brain by a drop in blood pressure. The brain cannot tolerate drops in blood pressure, and that's a -- you're going down very quickly when blood pressure drops.

Q. And so it was -- in your opinion,

that was the result of him jumping out of bed quickly?

A. That contributed to it, yes.

Q. Okay. And then I'm still not understanding then, how did his flu-like symptoms also contribute?

A. He gets sick. He has diarrhea, probably not eating and drinking adequately. He's volume depleted. He's laying supine for a period of hours -- and that's why this is such a typical spell -- and then he jumps up out of -- bounds out of bed in the morning, and his blood pressure doesn't have a chance to adapt.

Had he gotten up more slowly and dangled his legs, he would have probably not blacked out, and we wouldn't be having this conversation.

Q. Okay. When you say --

A. This is a very common -- this is a very common story about -- I mean, the older we get, the more common it is, and particularly in males, who do make it to the bathroom and then urinate and then develop a syncope, so this is a very common story.

Q. Mr. Carrillo was in his early 30s,

right?
A. Right, but -- syncope and fainting is very common, particularly in slender young women, but it happens in males as well, particularly in a situation like this. And this was an atypical occurrence because it's unique. It's the only time it has ever happened to him because he happened to be sick at the time, and that was a generator. Then the, quote, mistake that he made was jumping out of bed in the morning. That's not an uncommon story.
Q. Now, Doctor, when you say Mr. Carrillo was volume depleted, what do you mean by that?
A. Well, he hadn't been eating and drinking. He had low volume. In a situation like that, if you potentiate orthostatic hypertension by jumping out of bed, you have less volume and you go down.
Q. How can you measure the level of volume?
A. Well, you -- in a situation like this, I mean, you could do urine gravities. You could do other things to look at volume,

Q. So it sounds like there are objective measurements for determining whether somebody's volume is low; is that correct?
A. Objective measurements. There would be some, yeah, criteria that you could -- the history, again, would be very important. In a situation like this, you probably wouldn't bother with any of that. In this case, you take a history, if you can get one, in the ED, probably give him some fluids, check him out again, send him home, tell him not to jump up out of bed, and you would be done with it. That's probably -- that's how he would have been worked up in most EDs or Urgent Care centers if he came in that -- that morning.
Q. I appreciate that answer, Doctor, but that wasn't really my question. My question was, there are objective ways to measure whether somebody is volume depleted; is that right?
A. There would be -- at the time of the event, you would look at different -- urine concentration. Urine-specific gravity, you could look at. You could look at the hematocrit level and so forth to see if it was

but that wasn't done. And probably by two days later, if he started drinking fluids, he would be -- probably have corrected that. I mean, you, yourself, know, when people come in sick, the first thing you do in a situation like this is put an IV in and give them fluids because they are volume depleted. That's not uncommon. Fainting from being volume depleted is more uncommon, but at the same time, not infrequent.
Q. What level of volume depletion or dehydration would --
A. You don't measure --
Q. -- need to be at to --
A. You'd have to look at -- it depends on a variety of factors. What you want to do in him, if he came into the emergency room that morning, would be to do standing -- supine and standing blood pressures to see how much his blood pressure dropped because there are criteria for defining what orthostatic hypotension is, usually a drop of 20 milliliters of mercury of systolic pressure. Frequently the heart rate doesn't respond by going up, and down you go.

high, that would suggest volume depletion.
Q. Is it similarly true that there are objective measurements to determine whether somebody is dehydrated at a level that might put them at a risk for loss of consciousness?
A. Yeah, there would be some things that you could do that would be done in an ED.
Q. And none of those objective measurements exist in this case?
A. No, exactly, because he didn't go in that morning.
Q. And you would agree, in your report -- your expert report that you wrote, his blood work -- what was shown in his blood work, in your opinion, had no bearing on the episode of altered awareness?
A. Not that I can tell you, no.
Q. And then at the -- just above the comment section on -- still on the third page of your report, you wrote: Therefore, the current diagnosis remains unchanged from the initial diagnosis of an episode of transient loss of consciousness of unknown etiology; is that right?
A. That is correct. That's part one

of my report.
Q. And you are -- it's your testimony that you have now abandoned that opinion; is that correct?
A. Yes.
Q. You abandoned the opinion that you issued as your expert opinion in this case?
A. That's right, based on the history that everybody else was playing with and came up with the same opinions, picking out seizure more than syncope, except for the cardiologist, because as I said earlier, we were churning the same information. You can deal with that information -- 100 neurologists could deal with that information, and you couldn't say anything more than this, based on that information. You had to talk to the observer.
Q. And, Doctor, etiology, that's just a fancy word for cause; is that right?
A. Yes.
Q. And so then your next sentence, the first sentence in the comments section: To begin with, as stated above, the etiology of Mr. Carrillo's event remains unknown. That's no longer true, in your opinion; is that

correct?
A. Yes, and I think I make that pretty clear.
Q. Even though that's what you wrote as your expert opinion in this case?
A. Yes. And it is correct based on the information prior to that comment, just like most of the others who have evaluated him, whether it was Dr. Holland or Dr. Frankel or Dr. Aguilar, based on the information, they came up with a spell of uncertain etiology, but they leaned more towards epilepsy, but it's the same information that I had. Again, the other physicians that I've mentioned say roughly the same thing. You've got to take a history.
Q. So you didn't review the other physician's opinions as medically unreasonable based on the information --
A. Based on the information available. I don't know -- and you'll have to inform me whether they had a right or were allowed to speak to the observer since they were being called in by you. Dr. Holland should have, and Dr. Aguilar should have, in particular.

Q. Right. But whether they could have, it sounds like your opinion is based on the medically -- the information contained in the medical records, their opinions were not medically unreasonable?
MR. KASTER: I'm going to object to form and foundation, and it mischaracterizes the answer. You can answer.
THE WITNESS: It's not unreasonable based on the information available. Although I think the -- as I made clear, I think the -- leaning towards an epileptic seizure is difficult and has -- and is problematic, but not unreasonable.
BY MR. ORTBALS:
Q. And then this statement at the very bottom of the third page: From my perspective, a definitive diagnosis cannot be given based on the records I have reviewed.
A. That is correct and that still is correct, even though it's in the first part, and that's because of what I said at the end, the records I have reviewed.
Q. And based on the records you reviewed -- and I understand this is no longer

your opinion based on your conversation with Mrs. Carrillo.
A. Right.
Q. But based on the records you reviewed, even you could not rule out unprovoked seizure as a diagnosis; is that right?
A. Yes. As I made clear in my report, I leaned away from it, but I could not rule it out, correct.
Q. Then at the top of page 4 of your report, you wrote: If the episode was a seizure, the fact that it has not recurred for over four years following the late June 2017 episode does rule against it since approximately 80 percent of second seizures occur within two years of an initial unprovoked seizure; is that right?
A. Yeah, sure.
Q. And you didn't cite any medical literature for this 80 percent number; is that right?
A. No. It's a -- it's a commonly used statement coming from papers by Alan Hauser and others, Anne Berg, but it is -- it's

a guide post. It's not an absolute.
Q. Okay. Now, do 100 percent of patients who suffer an unprovoked seizure go on to suffer a second seizure?
A. Say that again for me, would you please?
Q. Sure. Do 100 percent of patients who suffer an unprovoked seizure go on to suffer a second seizure?
A. What percent?
Q. 100 percent. Do all patients who suffer a first seizure --
A. No. Lots of people have a single seizure and do not develop epilepsy. Another statistic is about 7 percent of Americans, sometime in their life, have a seizure without a diagnosis of epilepsy being established. It's not a rare occurrence.
Q. Okay. So this 80 percent number is actually a subset of those individuals who do go on to suffer a second seizure; is that right?
A. Yeah. The rule -- I mean, numbers are thrown around. It's estimated that -- by people like Hauser and Berg that maybe

50 percent of people who have a single seizure go on to have repeat seizures. These numbers are all soft. Again, in this case, it becomes an academic discussion because I don't think that's what Mr. Carrillo had.
Q. Well, regardless of whether it's academic or not, I mean, you would agree, ultimately, Doctor, the fact that you haven't had a second seizure does not mean that you didn't have a first seizure?
A. Oh, I see what you're saying. That's an interesting way of placing the statement, but the answer is true, you can have a single seizure and not have repeat seizures.
In that case, why was he fired?
Q. Well, Doctor, I'm asking you this way because you seem to be relying on the fact that he didn't have a second seizure as somehow evidence that he didn't have a first.
A. Well, that's, again, in the first part of this report. And we can sit here and we can churn this information, as I say, until tomorrow morning, but we're talking about, in my opinion, something he did not have.
Q. Right. I understand that your

opinion has changed based on a conversation four years later, but I'm still going to ask you questions about the opinion you gave in your expert report.
A. Well, as I say --
MR. KASTER: Hold on. Hold on, Doctor. Hold on, Doctor. I'm going to object. That's not what his expert report says. If you keep misstating his expert report, I'm going to tell you what it says, Bob.
MR. ORTBALS: I mean, Lucas, you're welcome to read it to me aloud. I can read as well. I appreciate it. I think I'm being perfectly fair with the doctor.
THE WITNESS: Please don't punish me for talking to Mrs. Carrillo four years later. I didn't have the opportunity to talk to her sooner, but about seven or eight physicians did and didn't talk to her, and that's why we're having -- you know, we're churning this information over and over again.
This fellow fainted, and it cost him his job. He fainted because he was sick, and it cost him his job.
BY MR. ORTBALS:

Q. Now, Doctor, based on this 80 percent number that you set forth -- and we can agree that the levels of risk for suffering a second seizure are going to be the highest in the first two years following an unprovoked seizure; is that right?
A. Yes.
Q. It's also true, Doctor, that the medical literature shows that there's still elevated risks of a second seizure three to four years after an unprovoked seizure?
A. Correct.
Q. And is it also true, Doctor, that at the time of initial evaluation, there's little way to predict exactly which patient will go on to have a second seizure?
A. Assuming they had a first seizure, yes. There are other predictors. Let me take that back. If an EEG was abnormal and showed epileptogenic activity, focal structural lesions on an MRI, that increases the ante of developing epilepsy after a first or single seizure.
Q. And in that circumstance, I think -- I'm trying to recall from the ILAE

definition of epilepsy we discussed yesterday. That sounds like those could be circumstances where the first unprovoked seizure coupled with the highly elevated risk of a second seizure could lead to an epilepsy diagnosis just based on that information?

A. Well, yeah, particularly the EEG, and we didn't get into that. We talked about this before, but if you have a single seizure and you have epileptogenic activity on an EEG in a -- that really increases the risk of going on to develop further seizures. It's not absolute, but it increases the risk significantly, in particular.

Q. But absent some type of measurement like that, it's going to be difficult to predict who might go on to have a second seizure following their first?

A. If you had a seizure, yes.

Q. And it's true, Doctor, that in 2017 and 2018, Union Pacific did not have the four-year look-back period that you mention here in the highlighted portion of your report?

A. Correct, for a seizure.

Q. Now, Doctor, you mentioned

convulsive syncope in your report. What is convulsive syncope?

A. It's a very common phenomenon for individuals to have movements in association with a syncopal episode, and these can be very modest and just some myoclonic-like jerks in various extremities, and it can be a little more profound and can actually involve some rigidity and clonic activity in the extremities, but usually it can be separated from epilepsy if observed.

Q. If observed by whom?

A. Well, by the -- certainly by the doctor, but -- most of the time, that doesn't happen -- but by the observer. As I indicated in my report, you know, lots of the words that you hear all the time when asked to have an observer -- shaking. What is shaking? Well, what does shaking mean? Shaking is, by no means, in and of itself a definition of having had an epileptic seizure. Lots of things shake that aren't a seizure.

Q. And so then, Doctor, is it your -- now your opinion that Mr. Carrillo's loss of consciousness was convulsive syncope?

A. Well, I -- it was a syncope. I don't know -- at least the description of the movements that I could take over the phone from Mrs. Carrillo had -- there was motor activity. Whether it rises to calling it convulsive syncope is uncertain. If he just had some scattered myoclonic jerks, you might not use that terminology.

Q. And what's --

A. There's no specific defining of convulsive syncope. If you look it up, they will talk about motor activity associated with a syncopal event.

Q. And so then what -- based on Mrs. Carrillo's description of the -- of Mr. Carrillo's movements or jerking during his loss of consciousness, I mean, how would -- how do you define them then?

A. Well, I think by what she told me and what she subsequently learned, having observed it in other -- in medical settings, what she described to me was myoclonus, just some kind of multifocal myoclonic-type activity.

Q. And so then are those movements

anything that you're relying on in determining that Mr. Carrillo had syncope?

A. Mr. Ortbals, could you say that again?

Q. Yeah. I'm just -- so the movements she described, are you relying on those in making your opinion that Mr. Carrillo suffered from syncope?

A. Yeah. Not solely on that, as I described, what she could recall. Certainly what she described was more consistent with -- in my estimation, with syncope than seizure and supported the remainder of the observations that she made.

Q. How do you differentiate the diagnosis of convulsive syncope from an unprovoked seizure?

A. Well, as best you -- as sometimes literature or textbooks will tell you, it can be done to a certain degree, with difficulty, but it's, again, taking a history, and over a series of phenomena, as you can see, when I asked her, that she could answer -- some things she couldn't -- it's collecting information of motor activity, skin color, duration of the

event, whether eyes were open or closed. All of these can help distinguish, although there's not one specific feature that you can call upon that makes for an absolute.

MR. KASTER: Hey, Bob, I'm not sure how much you have left, but could we take a break at some point?

MR. ORTBALS: Yeah. Let's go ahead and take that -- take a break. That's fine. Do you want to take ten minutes? Is that fine?

MR. KASTER: Sure.

MR. ORTBALS: Certainly.

THE VIDEOGRAPHER: Off the record at 2:20.

(Pause in proceedings.)

THE VIDEOGRAPHER: On the record, 2:30.

BY MR. ORTBALS:

Q. All right. Doctor, we're back on the record after a short break. I'll remind you that you are still under oath.

The next paragraph of your report, on page 4 of your report, references a diagnosis that had not been entertained that you thought was possible, and that is that Mr. Carrillo suffered

them up. I doubt there's any reason that he would do that, so they are due to something.

Q. Well, how do you -- how do you go about diagnosing a concussion, Doctor?

A. How do I know about diagnosing --

Q. What do you do to diagnose a concussion?

A. Take a history.

Q. Now, what, in somebody's history, would lead you to diagnose somebody as being concussed?

A. Well, having a head injury is important, and then it can be a variety of situations, which, of course, is all over the news today with -- in recent years with the NFL and the whole role of concussion. So it comes down to a history, was there a loss of consciousness, post-event symptoms which include headache, can include memory disturbances, can include anxiety and other mood changes and the like.

Q. And you agree there was no evidence in Mr. Carrillo's medical records of any external head trauma; is that right?

A. The only trauma that you would

from a concussion; is that right?

A. That's -- let me make it very clear. That is a speculation based on the information in the medical record. So that's -- just to let -- just to clarify that.

Q. So your opinion that Mr. Carrillo could have had a concussion is based on your own speculation?

A. Yeah, in terms of how to explain the symptoms that followed the event that began with the event. No one has really commented on it, the other physicians going over the record, and it is a curiosity. It doesn't support whether he had a seizure or a syncope in and of itself, so you have to look for another cause.

Q. And it sounds like you don't have enough information to diagnose him as having had a concussion.

A. Well, again, that's -- there is -- with concussions, there may be no specific way to determine that an individual had a concussion beyond the history and how to deal with a postconcussion syndrome.

So those symptoms, we all know, are due to something. I'm assuming he didn't make

look to would be (inaudible) --

Q. He didn't have any head contusions?

A. Correct.

Q. No lumps on his head?

A. Correct.

Q. No lacerations to his head?

A. Correct. And with the blunt closed head injury, you don't have to. Again, read the literature out of the NFL on this whole issue of concussion.

Q. Right, but you don't know that he had a blunt closed head injury.

A. No, other than the fact that the situation certainly could support that possibility, number one; and number two, we don't have another explanation for those symptoms. They have just, more or less, been ignored in all of the discussions.

Q. Then you say: Any suggested etiology, be it seizure versus syncope, requires speculation, exclamation point; is that right?

A. Yeah. That's been my contention all along.

Q. Is that still the case, or is it your position --
A. No, because again, as I said, the first part of this report is based on the information that we have all had available, and certainly I agree that speculation is required because the history was not complete, so that's -- I've been in situations like this before many, many times with unobserved episodes of syncope where somebody just collapses, and you struggle to try to come up with a diagnosis.
Q. And then the last paragraph of the first part of your report for the addendum, still on page 4 of your report, you express your concern about why it is that Mr. Carrillo has not been able to return back to work; is that correct?
A. Yes.
Q. And you state: It seems reasonable, based upon the job description and a common understanding of an electrician's duties, that Mr. Carrillo could return to work shortly after the event; is that right?
A. Yes.

Q. What's your understanding of Mr. Carrillo's job duties on which you're basing that statement?
A. Just general information that was available in all the reports that we see, I have -- and also from what he told me in my telephone conversation with him. I have no, you know, precise information beyond that.
Q. What do you recall about what he told you about his job duties?
A. Well, let's see. I didn't actually -- from the looks of this, I didn't really comment much on that because -- other than to say that I just spent a few moments about, you know, the risks in terms of his work as an electrician, and he didn't see any, but I didn't -- I didn't really comment on that.
Q. And I know I asked you some of these questions yesterday. I apologize that I need to re-ask them just because we're in a different case. Have you ever worked in the railroad industry?
A. No.
Q. Have you ever worked in a rail yard or locomotive shop?

A. No.
Q. Have you ever seen Mr. Carrillo's diesel electrician job performed?
A. Have I ever seen his what performed?
Q. Diesel electrician job.
A. Oh, no, no.
Q. Do you know what Union Pacific's job requirements for the position are?
A. No.
Q. Did you have any understanding that Mr. Carrillo moved locomotives within the yard and shop in which he worked?
A. I did see something to that effect in the information -- in the Union Pacific portion of the records that I have, but I don't know the details on that.
Q. Do you hold yourself out as an expert in occupational medicine?
A. No.
Q. Have you authored any articles on occupational medicine?
A. No.
Q. Have you conducted any peer-reviewed studies on occupational medicine?

A. No.
Q. Do you belong to any occupational medicine professional organizations?
A. No.
Q. Do you have any certifications in occupational medicine?
A. No, but I do know one thing. A fainting spell for being -- when you're sick doesn't rule out his doing any of the jobs that Union Pacific would outline for him, or at least it shouldn't.
(Thereupon, Exhibit 13 from a prior deposition, Aguilar record, was presented for purposes of identification.)
BY MR. ORTBALS:
Q. Doctor, I've shared what's previously been marked as Exhibit 13. Are you able to see that on your screen?
A. Yes, sir.
Q. Doctor, are you able to see Exhibit 13 on your screen?
A. I do.
Q. Okay. And this is an August 7th, 2017, medical note from Dr. Aguilar's visit with Mr. Carrillo; is that correct?

A. Yes.
Q. And this is one of the medical records you reviewed in preparing your report?
A. Correct.
Q. If we go to the sixth page of Exhibit 13, Bates numbered UPCARRILLO36 at the bottom, at the top of the Recommendations section, do you agree with me that Dr. Aguilar told Mr. Carrillo not to drive and to avoid any other activities in which Mr. Carrillo could sustain any injuries or cause injuries to others if a seizure were to recur? Is that right?
A. Given the information he had, that was most appropriate.
Q. And these are pretty typical seizure precautions; is that right?
A. Yeah. I'm sure he programmed that in and pushed a button, and that came up. Our residents do the same thing.
Q. You don't know that that's what he did though?
A. No, but I -- I can't prove it, but I know that's what he did. I mean, that's what we all do. You don't want to type the same

thing out each time, so you have statements like that that you just bring up. And that's fine. I have no problem with that.
Q. It sounds like you don't believe it was inappropriate to issue seizure precautions based on the information Dr. Aguilar had at the time?
A. That's correct.
MR. ORTBALS: I don't have any further questions.
MR. KASTER: I don't have any questions at this time.
THE VIDEOGRAPHER: Off the record at 2:43.
MR. KASTER: Doctor, I'll give you the same notice as yesterday. You have the right to read it. Are you waiving that?
THE WITNESS: I am, particularly since it's audiovisual and not some poor court reporter trying to keep up with me, so I completely agree.
MR. KASTER: Okay.
(Thereupon, an off-the-record discussion was had.)
THE NOTARY: Transcripts?

MR. ORTBALS: Electronic for us.
THE NOTARY: Two weeks?
MR. ORTBALS: That's perfect.
THE NOTARY: Copy?
MR. KASTER: Whatever our standard order is through Veritext.
(Thereupon, the deposition concluded at 2:45 p.m.)

STATE OF OHIO)
COUNTY OF MONTGOMERY) SS: CERTIFICATE
I, Mindy R. Huffman, a Notary Public within and for the State of Ohio, duly commissioned and qualified,
DO HEREBY CERTIFY that the above-named MICHAEL DEVEREAUX, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth.
Said testimony was reduced to writing by me stenographically in the presence of the witness and thereafter reduced to typewriting.
I FURTHER CERTIFY that I am not a relative or Attorney of either party, in any manner interested in the event of this action, nor am I, or the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Dayton, Ohio, on this 8th day of [illegible] March, 2022.

Mindy R. Huffman

MINDY R. HUFFMAN
NOTARY PUBLIC, STATE OF OHIO
My commission expires 3-21-2024

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BUILDING AMERICA®

HEALTH & MEDICAL SERVICES
Laura G. Gillis, MD, MPH, FACOEM
Chief Medical Officer
Phone: (402) 544-4679
Fax: (402) 233-3456

April 7, 2022

Mr. Joseph Carrillo
DOB: 05/23/1986
Employee ID: 0457172
Position: Electrician

Exhibit BBB

Re: Return to Work Fitness for Duty Evaluation

Dear Mr. Carrillo,

The Union Pacific Health and Medical Services (HMS) Department has many functions including assessing employee fitness for duty based on medical information. This information may be obtained from an employee's health care provider, a UP ordered medical examination or other health professional evaluations. We also take into consideration our knowledge of your work tasks and work environment. Our mission is to ensure that employees are safe to return to work, especially if they are in safety sensitive positions.

In June 2017, you experienced a loss of consciousness that was most likely a single unprovoked seizure of unknown cause. For this reason, you were given restrictions for a period of 5 years. This period will end in June 2022, and we would like to advise you on what information should be submitted for a return-to-work review. Based upon a review of your file, please submit the following for reconsideration:

1. Loss of consciousness/seizure history: Due to your previous history, please submit a full and comprehensive evaluation performed by a neurologist within the last 90 days to include a detailed interval history outlining any and all subsequent events involving seizures or loss of consciousness, current detailed physical examination, any functional restrictions that are recommended, treatment plan including medications, and prognosis. Please include copies of any clinically pertinent diagnostic studies that were performed.

2. If any other medical or mental health conditions have developed since 2018 that may potentially impact your ability to perform safety sensitive work, then please submit the last three (3) office visit notes from the treating providers for those conditions along with copies of any clinically pertinent diagnostic testing results.

Please feel free to have your providers contact me at any time with questions pertaining to this matter at (402) 544-4679.

I encourage you to work closely with your providers on this matter. I look forward to speaking with you in the near future.

Sincerely,

Laura Gillis, MD, MPH, FACOEM
Chief Medical Officer

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services